A study of untimely sudden deaths and people who took their lives while in the care of the Donegal Mental Health Service

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Foreword

Unexpected, tragic events with adverse outcomes present a huge challenge to individuals, health services, families and communities who are striving to do their best in stressful circumstances . In order to progress towards better mental wellbeing for all, we must question how we can help vulnerable people. This research has examined in depth and in detail those tragic circumstances that no one personally or professionally ever wishes to face.

To do this objectively, openly and with a fierce intent to use the findings to improve the identification of people at risk to sudden unexpected deaths in mental health services, examining the factors that contribute to risk and the consequences for families in the aftermath were key objectives of the research team. The findings revealed that no single factor dominated the cases examined. Each case had a complexity which underlined that any recommendations made needed a multifaceted, collaborative approach.

It is hoped that the research tools described, the recommendations made and the contributions of all the families who gave their time so unreservedly will help all mental health services in Ireland. This data set of consecutive untimely sudden deaths will contribute to suicide research internationally, but most importantly it helps cast light onto what must be done to provide effective suicide prevention in Ireland. When a series of unexpected deaths occurred in Donegal, local mental health services began to search for answers. We were fortunate to recruit expert assistance from Professor Ella Arensman and her team from the National Suicide Research Foundation. The NSRF, HSE managers, local Suicide Prevention Officer and local Mental Health Area Management team all came on board and did not shy away from trying to uncover answers. In particular I would like to thank our on-site researcher Dr Colette Corry for carrying out the research on the ground. I would also thank Mr Kieran Woods, Head of Psychology and Mr Kevin Mills, Director of Nursing who both contributed long hours reviewing clinical data.

The commitment shown by all parties in bringing this research project to fruition has been immense and therefore I feel privileged in contributing a foreword to such an important piece of work. Above all, I sincerely thank all the family members who gave up many hours of their time and shared painful topics to contribute to better understanding of people whose untimely deaths occur while they are users of mental health services. The altruism of the bereaved who want a better future for people with mental health difficulties was humbling.

Dr Clifford Haley,
Executive Clinical Director,
Donegal Mental Health Services

Foreword

Ireland's national suicide prevention strategy *Connecting for Life 2015-2020* sets out a vision of an Ireland where fewer lives are lost through suicide, and where communities and individuals are empowered to improve their mental health and wellbeing. This vision is realised through seven goals, one of which is to ensure safe and high quality services for people vulnerable to suicide.

A Study of Untimely Sudden Deaths and People who took their lives while in the care of the Donegal Mental Health Service helps us to better understand current practice, in relation to people vulnerable to suicide, in HSE Donegal Mental Health Service. The study examines the untimely sudden deaths and those who took their lives while in the care of HSE Donegal Mental Health Services between October 2011 and May 2015. It sets out six recommendations: increase understanding among mental health service staff about service user suicide and self-harm risk; prioritise uniformity of good practice; foster communication and engagement with family members; improve the service response to family members following the death of a service user; improve media reporting of suicide; and implement the the Suicide Support and Information System.

This study was commissioned following concern by the HSE Donegal Mental Health Service about the increasing number of premature deaths of its service users. This open approach, and willingness to review and learn from current practice, is vital to help ensure the quality and standard of the mental health service offered in Donegal.

Against this background, *A Study of Untimely Sudden Deaths and People who took their lives while in the care of the Donegal Mental Health Service* was funded by the HSE's National Office for Suicide Prevention to add to our understanding and improve our information, which are vital in order to better design effective responses. The learning from this study will also help inform studies in other counties, with an overarching aim of improving services and reducing the number of premature sudden deaths and suicides in Ireland.

I would like to offer a special thanks to all the family members who participated in this study. Their involvement offers us valuable insight into the family's experience of the mental health services, and the study recommendations outline how mental health services can improve communication with family members. I would also like to thank the General Practitioners, Coroner and Mental Health Service staff who participated in the study, and acknowledge the efforts of the research team, led by the National Suicide Research Foundation.

No single agency, no single Government Department, no single individual can reduce suicide on their own. If fewer lives are to be lost through suicide, and if communities and individuals are empowered to improve their mental health and wellbeing, then we must ensure that we continue to work together, to achieve our shared and attainable goal for all people of our nation.

Mr Gerry Raleigh, Director,
National Office for Suicide Prevention

Foreword

I welcome this timely report by the National Suicide Research Foundation. We recently launched *Connecting for Life Donegal,* the Suicide Prevention Plan for the county. This action plan outlines how many agencies and organisations will work together in the next five years to reduce the numbers of people dying by suicide in the county. Clearly the HSE and in particular the mental health service has an important role to play. This study provides us with a clear direction for what we need to do. There have been a number of new initiatives within the Donegal Mental Health Service in the recent past, such as the appointments of Self Harm Nurses in the Emergency Department of Letterkenny University Hospital and the Suicide Crisis Assessment Nursing service available to General Practitioners. Both of these services aim to provide an immediate assessment and early intervention service to people who may be at risk of suicide.

I am very grateful to the bereaved families who contributed their own very personal experiences to this report which will have an influence on mental health services across the country. We will ensure that we do everything we can to prevent death by suicide of service users and to support families who are bereaved. I will certainly ensure that this is the case across the services of the counties for which I am responsible. My thanks to Professor Ella Arensman, Dr Colette Corry and Ms Eileen Williamson at the National Suicide Research Foundation for conducting this sensitive and important study.

Mr John Hayes,
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A study of untimely sudden deaths and people who took their own lives while in the care of the Donegal Mental Health Service Management Team

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This study was commissioned and funded by the National Office for Suicide Prevention (NOSP). We sincerely thank NOSP for their support and collaboration.

We thank Coroner Mr John Cannon for his support and collaboration during data collection from coronial files.

Our gratitude to those General Practitioners in the Donegal region who took time to participate in this important project, the data provided is invaluable.

Special thanks to Ms Mary Anderson from the Psychiatric Unit at Letterkenny Hospital for her administrative support.

We would like to express our sincere thanks and appreciation to all family members who participated in the family informant interviews. The information and insights which they provided will help us make major steps forward in suicide prevention.

Executive Summary

This report was commissioned by the Donegal Mental Health Service and funded by the National Office for Suicide Prevention (NOSP). The study examined untimely sudden deaths and those who took their lives while in the care of Donegal Mental Health Service between October 2011 and May 2015. As such, it does not include cases where death occurred in the absence of a recorded history of clinical interaction with services. Information was gathered in accordance with the principles of the Suicide Support and Information System – Psychological Autopsy Model, SSIS-PAM (Arensman *et al*, 2012; 2013), and in line with the *Reach Out* National Strategy for Action on Suicide Prevention 2005-2014 (HSE, 2005).

The SSIS model is innovative as it was developed to prevent suicide by pro-actively facilitating access to support for the bereaved while at the same time obtaining information on risk factors associated with suicide and deaths classified as open verdicts using a systematic and standardised procedure.

The SSIS objectives are in line with key strategic goals and actions of the new National Strategy to Reduce Suicide in Ireland, *Connecting for Life*, 2015-2020.

- Developing a uniform procedure to respond to suicidal behaviour across mental health services.
- Implementing a system of services review based on incidents of suicide and suicidal behaviour within HSE mental health services and developing a responsive practice model.
- Improving the uniformity and effectiveness of support services for families bereaved by suicide.

A key component of the SSIS-PAM is its capacity to collect information from multiple sources to corroborate the clinical history of the deceased while also reaching out to family members who may need support in the aftermath of such a tragic event. Within the framework of the SSIS-PAM model, data was collected from multiple sources including medical records, close family members or friends, coroner's records and post-mortem reports, and healthcare professionals. In addition to the altruistic benefits of participation, it offered the opportunity to discuss personal feelings of loss and experiences of service interaction in a confidential setting with the benefit of psychological support. To protect the memory of the deceased and ensure no further distress to the bereaved, no individual is directly referred to or identifiable throughout the report.

This study can be considered a national exemplar for a number of reasons. First and foremost, it was a commission borne out of concern by the Donegal Mental Health Service, which sought insight into an increasing number of premature deaths of its' users in the knowledge that reporting at this level may raise further questions. In addition, it acknowledges the need for a review of current process and policy within local mental health services. It is unique in that it has offered family members a voice and has ensured that findings reflect both the positive and negative aspects of service delivery and experience.

The current system of recording suicide and sudden unexpected deaths which may have been the result of suicidal or self-harming behaviour

remains challenging at both local and national level. Official figures are usually measured by calendar year and remain provisional for up to two years post-event. What this means is that if a death occurs in one year, it may not be recorded in official statistics until two years later, due to coronial and other legal registration procedures. In smaller communities, particularly those in a rural context such as County Donegal, these figures can become distorted when reported in such a way, and while they may be adequate for national reporting purposes, they may fail to address the true incidence of suicide in a community at a particular time. As a result of the current research, DMHS now has a 'real-time' database of information on socio-demographic, psychosocial and psychiatric risk factors which may have contributed to the deaths of those in their care through untimely events or suicide. This database provides current rates of such events and is unconstrained by national figures which can take up to two years to be confirmed due to the legal process.

Maintenance of such robust data will have important consequences in the planning and implementation of policy and resources such as a targeted response to suicide contagion and emerging suicide clusters.

It is intended that SSIS-PAM will continue. High response rates, positive feedback and rich data collection have influenced the decision to rollout the current SSIS-PAM in four further counties with the potential for national implementation. Prior to publication, a number of recommendations are already being processed, with the overarching aim of improving services and reducing the number of premature sudden deaths and suicides in Ireland. One of these is the development of a treatment trajectory/service pathway for every service user presenting with current or a previous history of suicide attempts, risk or intent. Recording such detailed information provides an opportunity to consider periods of engagement and withdrawal from services and compliance with uptake, while providing a comprehensive case summary which details referrals, admissions, agency involvement, discharge and appointments the deceased failed to attend. This detailed information allows examination of the service provision and uptake of individual cases and identifies episodes of dis-engagement both by the service user and services.

Key Findings

A total of 34 deaths were included. Of these, 24 family informant interviews took place. Over 92% of those approached agreed to take part, representing a response rate well in excess of comparative international research.

Contact with General Practitioners involved in the care of the deceased was contingent on family permission following interview (n=24). A total of 21 families gave the necessary consent. Response rates were lower among General Practitioners, with two thirds of the questionnaires being completed and returned (n=13, 61.9%). Due to a change of Coroner and outstanding inquests, it was not possible to fully complete this part of the information process (cases completed: n=18; cases remaining: n=15). However, this will be addressed at a later date.

Men were overrepresented among those who had died by suicide or sudden unexpected death (67.8%) and were younger (mean=41.4 years, SD=13.5) than women (mean=44 years, SD=15.5).

The clinical files of all 34 cases were examined with regard to cause of death. Overdose of medication or drugs accounted for the largest loss of life (n=15, 44%) followed by hanging (n=14, 41%) and drowning (n=5, 14.7%). Almost half of the cases being examined were known to abuse both drugs and alcohol prior to death (n=16, 47%), six had abusive or dependent issues with a single substance while more than one third were reported to abuse neither drugs nor alcohol.

History of self-harm was known for a high proportion of cases (n=26, 76.5%), of which almost half had engaged in at least one act of self-harm. Overall, 17 of the deceased had engaged in self-harm within 12 months prior to end of life.

A total of 31 of the 34 deceased service users had a history of at least one voluntary or involuntary inpatient psychiatric admission. Service users aged between 34 and 39 years had the highest rates of multiple admissions and those aged 50-63 years had the lowest. During assessment, seven service users disclosed previously unreported incidents of self-harming behaviour. Six deaths occurred between 24 hours and four weeks post-discharge from mental health services and three between one and two months. A further eight deaths took place between three and nine months following service engagement and 14 people died at least one year later.

Psychiatric diagnosis was confirmed in all 34 cases with the majority (85%) also meeting criteria for a secondary disorder. Primary diagnosis of depressive disorder was most frequently observed (n=16, 47%). A secondary diagnosis of substance abuse was recorded in 47% of cases, representing more than half of those examined.

The majority of the deceased were being prescribed medication for mental illness preceding death (82%), with the highest rates observed in those aged between 34 and 63 years (50%). Men were three times as likely to be in receipt of multiple prescribed medications (n=9, 26.5% of total prescribing). Of the 34 cases being examined, 82% were described as non-compliant in clinical records and corroborated (where possible) by family members, GP reports and coronial files.

Among the deceased, the majority (n=18) had family members with known mental health issues, which was similar for both males and females. The most common mental health issues experienced by family members were depression and substance abuse.

In total, 44% of files contained incomplete assessments of suicidal risk, recorded in a manner too diffuse to be deemed informative of the service user's suicidal state. In the remaining 19 cases (56% of total) however, appropriate evaluation was conducted and made available in accordance with best practice principles.

The issue of service user confidentiality and subsequent clinical disclosure was at the core of most concerns reported by 13 family members, representing more than half of the total interviewed.

Bereaved men reported more often symptoms of depression following the death of a loved one while bereaved women more often experienced symptoms associated with anxiety. Of the 24 interviews conducted with family members, concerns about service delivery prior to the fatal event were reported in 13 cases (54%). These included risk assessment, clinical decisions about leave or discharge from the psychiatric unit, mental health legislation and policy and unsatisfactory interactions with hospital staff.

Overall, journalistic reporting was mindful of the effect over-sensationalised reports can have on family and friends of the deceased, as well as the community.

Recommendations and Actions

The following 6 recommendations covering 19 actions are based on findings relating to characteristics of the deceased, patterns regarding contact with the mental health services, and needs of families bereaved by suicide.

RECOMMENDATION

Rationale

Examination of current risk assessment procedures including the process of recording information in clinical files has highlighted a need for on-going staff training to advance understanding of the complexities of suicidal behaviour, particularly in cases of dual diagnosis and other risk factors such as age, gender and previous history of self-harm. Initial estimation of risk will almost certainly change throughout treatment and must be regularly reviewed. Therefore it is recommended to:

1. Improve clinical practice to increase understanding among mental health service staff about service user suicide and self-harm risk that is mindful of gender, age and other factors which may influence risk of premature death.

2. Prioritise uniformity of good practice supported by on-going training and supervision in relation to suicide and self-harm risk assessment. Ensure implementation at both induction stage and at regular intervals thereafter for all clinical staff.

ACTIONS

(a) As part of the staff induction process, provide evidence-based training on assessment and management of service users with (potential) risk of self-harm and suicide across *all* sections of DMHS, including Consultants and NCHDs.

(b) Following induction, the provision of a programme of training on a regular basis for *all* clinical staff will sustain expertise and enhance developing skills. Identify training needs and communication skills in the in-patient centre with particular focus on a rolling programme using a Train-The-Trainer model to maintain a high level of knowledge of suicidal behaviour and related mental health problems.

(c) Review current procedures of recording information included in clinical records to improve consistency in evidence based risk assessment and management of service users at risk of self-harm and suicide within mental health settings. Establish an on-going auditing process to ensure continuity of clinical recording, risk assessment and management plans.

(d) Ensure protected supervision time for *all* staff involved in suicide risk assessment.

(e) Introduce the treatment trajectory[1] system at admission for each service user presenting with risk of suicide and self-harm (see Glossary). Review clinical records to provide clarity and provide support for multi-disciplinary care planning, dual diagnosis and gaps in treatment.

(f) Following principles of best practice, select a short-form risk assessment tool for repeated measures during in-patient treatment to promote understanding of the changing and fluid nature of the suicidal risk continuum and incorporating dual diagnosis, substance misuse and fluctuating symptom levels.

(g) Implement a pro-forma questionnaire to assess patient views of treatment and experience of being on unit or in outpatient care and put a system in place which will review and respond to this feedback.

[1]Treatment trajectory: a comprehensive case summary which details referrals, admissions, agency involvement, discharge and appointments the deceased failed to attend. This allows examination of service provision and uptake of individual cases and identifies episodes of disengagement both by the service user and services.

RECOMMENDATION

Rationale

Family members perceived procedures with regard to disclosure, legal process, patient autonomy and staff hierarchy as a barrier to effective treatment. Both family members and service users consistently expressed their inability to communicate with certain staff, caused primarily by a failure to orally understand some psychiatric team members during consultation. In addition, some family members felt that valuable collateral information they offered to staff was dismissed by the clinical team. It must be noted that anxiety may often manifest as anger and negatively affect relations between family and clinician. Therefore, it is recommended to:

3. Foster communication and engagement with family members of service users with regard to the formal clinical structures and routine of in-patient psychiatric care.

ACTIONS

(a) Provide training in communicating with families as an important feature of induction for *all* clinical staff including NCHDs, and as a core component of subsequent training.

(b) Up skill *all* clinical staff members to engage with and recognise the value of collateral information provided by family members during the treatment process. Support family members of mental health service users on an on-going basis.

(c) Ensure family members and service users are aware that they can request extra staff support in clinical consultations.

(d) Ensure family members are aware of MHS procedures such as the admission process. Develop an information pack addressing treatment, policy and legal process for family members and service users at the time of admission.

(e) Be informed by best practice models with regard to disclosure of risk to family members and/or others. Incorporate as a core component of both the induction process and subsequent training for *all* clinical staff.

RECOMMENDATION

Rationale

The study revealed a lack of uniformity with regard to official procedures in the event of a sudden death. Reported contact with family members was variable and highlighted shortcomings in communication and signposting to qualified and specialised bereavement support services. These findings underline the need to:

4. Improve the service response to family members in the aftermath of death of a service user.

ACTIONS

(a) In addition to the informal contact with family members currently made by staff following a tragic death, establish a formal acknowledgement of the tragic event by letter from the mental health service, including practical information and signposts to available support services in their area.

(b) Ensure an appropriately timed telephone call from DMHS to ascertain the needs of family members as they come to terms with their loss.

(c) Ensure collaboration with the local Suicide Bereavement Liaison Officer in order to streamline provision of information and support.

RECOMMENDATION

Rationale

Overall, journalistic reporting was mindful of the effect over-sensationalised reports can have on family and friends of the victim, as well as the community. This is already being demonstrated through positive, continued dialogue with media outlets throughout the county. However, between 10% and 30% of the media articles failed to comply with the media guidelines. These findings underline the need to:

5. Improve media reporting of suicide, in particular in relation to avoiding reporting of specific details and personal information.

ACTIONS

(a) In keeping with objectives of *Connecting for Life Donegal*, reinforce on-going implementation of and adherence to the media guidelines for reporting of suicide through regular briefings.

(b) Work with local media to organise an annual meeting to promote the Media Guidelines for Reporting on Suicide and maintain good practice.

RECOMMENDATION

Rationale

The feasibility of the implementation of the Suicide Support and Information System Psychological Autopsy Model (SSIS PAM) in the Donegal Mental Health Service and high response rates support the wider implementation of this model in mental health services in other regions in Ireland. Therefore, it is recommended to:

6. Implement, monitor and evaluate the integration of the SSIS PAM under the remit of the new National Strategy for Suicide Prevention, *Connecting for Life*, 2015-2020 and local suicide prevention plans such as *Connecting for Life Donegal*.

ACTIONS

(a) Sustain the SSIS PAM in County Donegal, with plans for further implementation in other areas of CHO1 (Cavan, Monaghan, Sligo and Leitrim) as vital to good governance and reducing the number of sudden untimely deaths, especially suicides, among users of mental health services.

(b) Acknowledge contribution of the current study to the area of suicide prevention and the new strategic framework *Connecting for Life*.

1. Introduction

The principal objective of the current study was to examine cases of suicide and 'sudden, untimely death' which took place among users of the Donegal Mental Health Service between October 2011 and May 2015.

The Suicide Support and Information System – Psychological Autopsy Model (SSIS-PAM) is based on the Suicide Support and Information System (SSIS), which has been implemented and evaluated successfully in Cork City and County since September 2008 (Arensman *et al*, 2013; 2012; Windfuhr, 2010), and was funded by the HSE National Office for Suicide Prevention. The SSIS is innovative as it was developed to prevent suicide by pro-actively facilitating access to support for the bereaved while at the same time obtaining information on risk factors associated with suicide and deaths classified as open verdicts using a systematic and standardised procedure.

Specific objectives of the Suicide Support and Information System are to:

1. Improve provision of support to people bereaved by suicide.
2. Better define the incidence and pattern of suicide in Ireland.
3. Identify and better understand the causes of suicide.
4. Reliably identify individuals who present to health services due to self-harm and who subsequently die by suicide.
5. Identify and improve the response to clusters of suicide and extended suicide (e.g. filicide-suicide and familicide).

The original model was augmented to increase its utility within a mental health setting in County Donegal. In 2014, the Clinical Director of Psychiatric Services requested a summary audit of the characteristics of people who died prematurely with a presumed cause of death by suicide while in the care of the Donegal Mental Health Service (DMHS) between early October 2011 and May 2015.

The principal objective of this research was to formulate recommendations which would assist DMHS in dealing with service users at risk of suicide or sudden untimely death.

Using the infrastructure of the SSIS, an in-depth examination of the consecutive premature deaths was conducted to address the following specific objectives:

1. Identify the risk factors associated with premature deaths with a presumed cause of death by suicide among the people involved and to investigate common factors.
2. Examine whether there are any common factors or patterns among the people involved in relation to access to and use of the mental health services.
3. Examine whether there were any direct or indirect relationships or connections between the people involved and to investigate the extent of contagion.

A key component of the Suicide Support and Information System – Psychological Autopsy Model (SSIS-PAM) is its capacity to systematically collect information from multiple sources, which can be verified and representative of a standardised data capture format. This provides clarity for research and analysis of data pertaining to individual cases of suicide and sudden untimely death, thus minimising potential for interpretative bias. Within the framework of the SSIS-PAM model, data will be collected from multiple sources including medical records, close family members or friends, coroner's records and post-mortem reports, and healthcare professionals. The research was funded by the HSE National Office for Suicide Prevention.

2. Background

The SSIS is innovative as it was developed to prevent suicide by facilitating access to support for the bereaved while at the same time obtaining robust information on risk factors associated with suicide and deaths classified as open verdicts, which is in line with key priorities of *Reach Out* (HSE, 2005), the Reports of the Houses of the Oireachtas Joint Committee on Health and Children (Joint Committee on Health & Children, 2006; Joint Committee on Health & Children, 2008), and the Form 104 Report *Inquested Deaths in Ireland* (NSRF, 2007; Corcoran & Arensman, 2010). The objectives of the SSIS are also in line with priorities stated in the Coroners Bill (Coroners Review Group, 2007). The NOSP provided funding for a pilot study in the Cork region.

The SSIS objectives are in line with key strategic goals and actions of the new National Strategy to Reduce Suicide in Ireland, *Connecting for Life*, 2015-2020.

- Developing a uniform procedure to respond to suicidal behaviour across mental health services.
- Implementing a system of services review based on incidents of suicide and suicidal behaviour within HSE mental health services and developing responsive practice model.
- Improving the uniformity and effectiveness of support services to families bereaved by suicide.

In Ireland, national suicide statistics are provided by the Central Statistics Office (CSO). However, the annual suicide figures ('year of occurrence figures') are usually published with a delay of 2 years or longer. In addition, the available information on characteristics of people who die by suicide is mostly limited to demographic information. In order to implement timely and evidence informed intervention and prevention programmes, it is important to have access to a real-time register of suicides that will assist development of effective policy and the direction of appropriate resource allocation.

Preparations to develop the Suicide Support and Information System go back as far as 2005 when the NSRF, in collaboration with the NOSP, started consultations with key stakeholders such as the Department of Health, Department of Justice and Equality, the Coroners Society of Ireland, the Central Statistics Office (CSO), An Garda Siochana and mental health and primary care services. In addition, intensive consultation has taken place with the National Confidential Inquiry into Suicide and Homicide at the University of Manchester, a unique suicide information system which was established in 1995 (Kapur *et al*, 2013; Appleby *et al*, 1999). In line with a recommendation from the *Choose Life* National Suicide Prevention Strategy in Scotland, the National Health Services Scotland has also initiated the Scottish Suicide Information Database (ScotSID) to provide a central repository for information on all confirmed and probable suicide deaths in Scotland in order to support epidemiology, preventive activity and policy making (Information Service Division, 2012).

INCIDENCE RATES OF SUICIDE AND DEATHS OF UNDETERMINED INTENT IN IRELAND, 2004-2013

Rates of suicide per 100,000 by gender in Ireland for the period 2004-2013 are presented in Table 1. At present, the latest confirmed suicide figures published by the CSO are for the year 2013; 10.6 per 100,000 for the total population in Ireland, 17.2 for men and 4.1 per 100,000 for women.

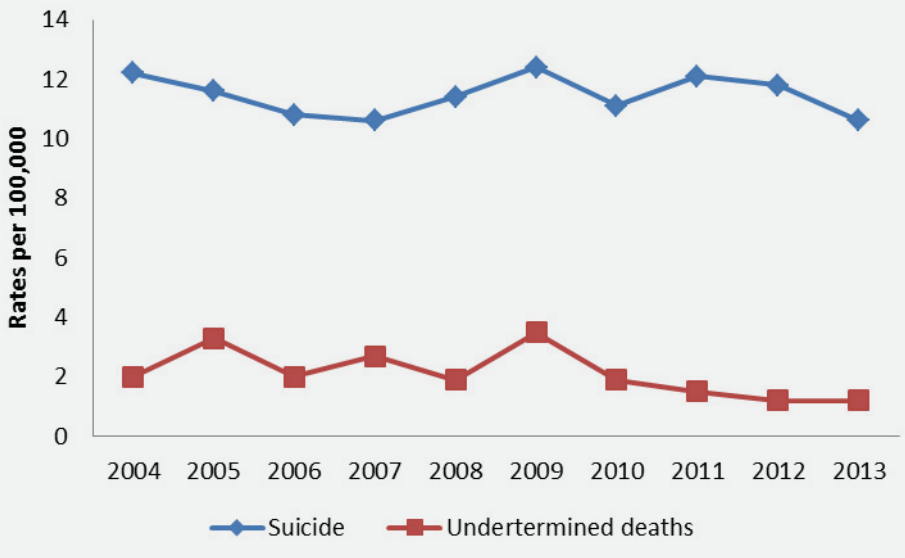
An initial decreasing trend in suicide was observed for men between 2004 and 2007, followed by an increase in 2008 and 2009, with a subsequent reduction in 2010. While rates remained relatively stable for women between 2011 and 2013, an increase was observed among men in 2011 with rates rising from 18.3 to 20.2 per 100,000 of the total population. Even though less pronounced, the rates for women show a fairly similar trend over the 9 year period.

Table 1: Suicides in the Republic of Ireland, 2004-2013

YEAR	TOTAL		MALE		FEMALE	
	NO.	RATE PER 100,000	NO.	RATE PER 100,000	NO.	RATE PER 100,000
2004	493	12.2	406	20.2	87	4.3
2005	481	11.6	382	18.5	99	4.8
2006	460	10.9	379	17.9	81	3.8
2007	458	10.6	362	16.7	96	4.4
2008	506	11.4	386	17.5	120	5.4
2009	552	12.4	443	20.0	109	4.9
2010	490	11.0	405	18.3	90	4.0
2011	554	12.1	458	20.2	96	4.1
2012	541	11.8	445	19.6	96	4.1
2013	487	10.6	391	17.2	96	4.1

There are indications that deaths of undetermined intent may include 'hidden' cases of suicide (Arensman *et al*, 2012; Linsley *et al*, 2001; Cooper *et al*, 1995). However, it is not yet clear which proportion of undetermined deaths may involve suicide cases. Figure 1 presents the rates of suicide and undetermined deaths per 100,000 of the population in Ireland, 2004-2013. The highest rate of suicide was 12.4 per 100,000 in 2009 and the highest rate of undetermined deaths was 3.2 per 100,000 in 2005. Looking at the trends over time, there is a remarkable pattern in that in most years when undetermined death rates are decreasing, suicide rates are increasing. Considering this pattern, and together with findings based on a comparison of confirmed suicide cases with open verdict cases in terms of psychosocial and psychiatric characteristics which revealed more similarities than differences (Arensman *et al*, 2012), further in-depth investigation into undetermined deaths is required.

Figure 1: Suicides and undetermined deaths in Republic of Ireland, 2004-2013



SUICIDE RATES IN COUNTY DONEGAL VERSUS IRELAND

The current system of recording suicide and sudden unexpected deaths which may have been the result of suicidal or self-harming behaviour remains challenging at both local and national level. Official figures are usually measured by calendar year and remain provisional for up to two years post-event. What this means is that if a death occurs in one year, it may not be recorded in official statistics until two years later, due to coronial and other legal registration procedures. In smaller communities, particularly those in a rural context such as County Donegal, these figures can become distorted when reported in such a way, and while they may be adequate for national reporting purposes, they may fail to address the true incidence of suicide in a community at a particular time. This has important consequences in the planning and implementation of policy and resources such as a targeted response to suicide clusters. Family views and lack of robust evidence can have a further significant impact when determining cause of death. Consequently, it is accepted by policymakers and research agencies that deaths attributable to suicide are likely to be underreported. In consideration of the current research, it is important to reiterate that it considers the background of only those deceased by suicide or sudden untimely death who were also under the care of Donegal Mental Health Services; as such, it does not include incidents where death occurred in the absence of a recorded history of clinical interaction with services.

Official figures for deaths by suicide throughout Ireland are reported in Table 2 (CSO, 2014). When weighted for area by residence, Donegal ranked 30 in Ireland with a suicide rate of 9.1 per 100,000 of the population. Of the constituent counties of the Community Health Organisation comprising Donegal, Sligo, Leitrim, Cavan and Monaghan, Donegal had the lowest rate, followed by Sligo at 9.3/100,000 of the population. Cavan reported the highest incidence rate at 14.1/1000. Of the remaining, Leitrim and Monaghan were relatively similar with reports of 13/100,000 and 12.5/100,000 respectively.

Table 2: Suicide by Area of Residence 2007-2013

ORDER	AREA OF RESIDENCE	RATE (PER 100,000)
1	Limerick City	17.7
2	Cork City	17.3
3	Wexford	15.4
4	Kerry	14.9
5	Offaly	14.6
6	Carlow	14.6
7	Cavan	14.1
8	South Tipperary	13.9
9	North Tipperary	13.8
10	Mayo	13.8
11	Laois	13.6
12	Clare	13.3
13	Westmeath	13.3
14	Leitrim	13.0
15	Louth	12.6
16	Cork County	12.5
17	Monaghan	12.5
18	Galway County	12.4
19	Roscommon	12.3
20	Limerick County	12.0
21	Waterford County	11.9
22	Kildare	11.3
23	Kilkenny	11.0
24	Waterford City	10.7
25	Dublin City	10.3
26	Galway City	9.7
27	Longford	9.5
28	Sligo	9.3
29	Meath	9.3
30	**Donegal**	**9.1**
31	Wicklow	9.1
32	South Dublin	8.8
33	Dun Lgh.Rathdown	7.2
34	Fingal	6.2

RISK FACTORS ASSOCIATED WITH SUBGROUPS AMONG PEOPLE WHO DIE BY SUICIDE

Identifying patterns of risk factors or risk profiles associated with suicide is challenging due to the heterogeneity of risk factors (Windfuhr & Kapur, 2011; McLean *et al*, 2008; McGirr *et al*, 2006), cultural differences (Amitai & Apter, 2012; Colucci & Martin, 2007) and on-going changes in risk factors over time (McLean *et al*, 2008; Nock, 2008; Beautrais, 2005). In Ireland, there is consistency regarding some demographic and psychosocial factors associated with suicide. Young men aged 15-39 years and middle-aged women (45-55 years) consistently show an increased risk of suicide (Malone, 2013; Arensman *et al*, 2012). In terms of psychosocial factors, increased suicide risk is associated with presence of depression, alcohol and drug abuse, history of non-fatal self-harm and recent experience of suicide by a family member or friend by suicide (Arensman *et al*, 2013; Malone, 2013). However, in order to improve early identification of people at risk of suicide and specificity of risk prediction procedures, it is required to improve our knowledge on risk profiles encapsulating the co-occurrence of the factors involved (Logan *et al*, 2011; McLean *et al*, 2008). For example, the initial outcomes of the SSIS-PAM as implemented in Donegal showed that having a family history of mental disorder was significantly associated with risk of suicide (Arensman *et al*, 2013). Yet, it is unclear whether there are any other co-occurring risk factors which further contribute to increased suicide risk.

The relatively small number of suicide cases examined (N=34) and access to multiple sources of information accessed through the SSIS enabled further in-depth investigation of potential subgroups and patterns of risk factors associated with suicide in County Donegal.

SUICIDE CLUSTERING AND CONTAGION

Internationally, there is growing public and professional interest in clustering and contagion in suicidal behaviour. There are indications of increasing clustering and contagion effects in suicidal behaviour associated with the rise of modern communication systems (Larkin & Beautrais, 2012; Robertson *et al*, 2012). Yet, the research in this area and information on effective response procedures and prevention strategies are limited (Haw *et al*, 2013; Larkin & Beautrais, 2012). Even in recent times, Boyce (2011) referred to the lack of research as "*Suicide clusters: the undiscovered country*".

The methodological approaches in assessing clustering and contagion of suicidal behaviour are wide ranging and internationally, there is a lack of consistency regarding the definition of clustering and contagion and regarding the statistical techniques assessing spatio-temporal aspects (Haw *et al*, 2013; Larkin and Beautrais, 2012; Mesoudi, 2009).

Suicide clusters are generally distinguished into two different types: mass clusters and point (space-time) clusters. A mass cluster is commonly defined as "*a temporary increase in the total frequency of suicides within an entire population relative to the period immediately before and after the cluster, with no spatial clustering*". Mass clusters are typically associated with high-profile celebrity suicides that are publicised and disseminated in the mass media (Haw *et al*, 2013; Hegerl *et al*, 2013; Ladwig *et al*, 2012; Mesoudi, 2009; Stack, 2000).

A frequently used definition to indicate a point cluster is "*a temporary increase in the frequency of suicides within a small community or institution, relative to both the baseline suicide rate before and after the point cluster and the suicide rate in neighbouring area*" (Haw *et al*, 2013; Mesoudi, 2009; Joiner, 1999; Gould *et al*, 1990). Based on a recent review, contagion is a concept derived from the study of infectious diseases and increasingly applied to cluster suicides. The underlying assumption is that "*suicidal behaviour may facilitate the occurrence of subsequent suicidal behaviour, either directly (via contact or friendship with the index suicide) or indirectly (via the media)*" (Haw *et al*, 2013). Those who are part of an at-risk population and have geographical and psychosocial proximity to a suicide are particularly vulnerable.

PATIENT CONFIDENTIALITY AND DISCLOSURE TO CAREGIVERS

Patient confidentiality is a complex issue, fraught with difficulty for both clinician and caregiver. While medical healthcare is generally planned in collaboration with a service provider, patient and family, mental health services must consider the implications of sharing sensitive information which may compromise the patients' rights to be treated in a secure and confidential environment. In contrast, there can be repercussions if critical information is withheld from care givers who are then excluded from important decisions involving the patient, for example when the safety of the patient and/or others is in danger. This can result in serious practical, financial and personal consequences for both the caregiver and the patient. Not being involved may also contribute to feelings of isolation, grief and subsequent loss in the event of a tragic outcome.

Professionals working in mental health services are bound to a duty of confidentiality to their patients by professional codes of conduct and legal process as defined by the Mental Health Act 2001 and the Mental Health Commission. A breach of this confidence can lead to disciplinary measures and legal proceedings. They also have a duty of confidentiality to caregivers. The most important issue is clarifying patients' agreement to disclosure of information to the caregiver, many of whom are unaware of this and do not realise that the patient must give consent before any information can be shared. Issues can arise when the patient is unable to give 'informed consent', for example at certain times during an acute psychotic episode or when the patient is suffering from Alzheimer's disease. Paradoxically, the caregiver is typically the one who knows the patient best and may represent the primary source of support. Care-givers also face problems with information-sharing, particularly in cases where the patient may not realise the extent of their illness or relapse, thus considering any action taken by the caregiver on their behalf to be a breach of trust. As such, important information about the patient may be lost if the caregiver is not involved in the assessment phase, treatment planning, compliance and maintenance. With prior knowledge and understanding of treatment decisions, particularly when multiple agencies such as community health nursing or occupational therapy are involved, the caregiver may act as the conduit between patient and services in the event of crises beyond a mental health setting. Other issues such as gaps in staff training regarding the management of complex issues associated with disclosure, combined with time constraints, may additionally impact negatively on communication between the mental health professional and caregiver.

While the 'Mental Health Act 2001' lists patient rights to information, the issue of disclosure to family members and/or caregivers remains undefined. However, in 2008 the Health Service Executive stated that a caregiver has the right to '*collaborate in your relative's care with their (patient's) consent.*' This is on the premise that the caregiver understands what is expected of them in return, and that *'clear boundaries are in place regarding family involvement, and communication between families and the mental health service is in accordance with the wishes of the service user'* (Mental Health Act, 2008).

Under the current Mental Health Act and reiterated by the Mental Health Commission, all patients are automatically afforded the right to privacy in matters involving health reporting, help-seeking and all subsequent clinical records pertaining to same. In outstanding cases where perceived risk to another is suspected, or when a serious crime is disclosed, it is within the boundaries of law that the clinical team informs the relevant authority and/or the individual(s) deemed at risk of harm. Adherence to this law is the model generally accepted by the medical field, but also subject to some degree of latitude should the clinician deem it appropriate. Variability may be due to confounders such as lack of experience or training in this area, underestimation of risk, personally held beliefs, or altering relationship dynamics between patient and caregiver, patient and clinician and caregiver and clinician.

3. Methods

MULTIPLE SOURCES OF INFORMATION

The SSIS-PAM has been implemented in County Donegal from July 2014. The SSIS operates according to a stepped approach whereby STEP 1 involves pro-active facilitation of support for family members bereaved by suicide, followed by STEP 2, obtaining information from different sources including information from medical records and coronial files, family informants and health care professionals who had been in contact with the deceased in the year prior to death (Figure 2).

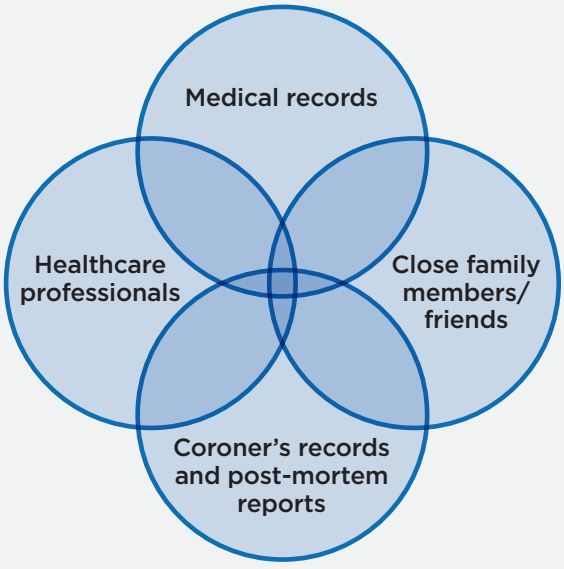
CLASSIFICATION CRITERIA FOR DETERMINING SUICIDE

The sample comprised all cases of suicide and sudden untimely death among users of mental health services throughout County Donegal which occurred between October 2011 and May 2014 (n=26). By subsequent agreement with the steering group a further eight cases of suicide beyond this time frame (until May 2015) were added to the existing sample, thus increasing the overall sample to 34 people.

The death must have been self-inflicted without suspicion of interference from others and there must be evidence to suggest that the deceased intended to cause his/her death. In some cases, the means by which the deceased caused his/her death may clearly indicate that it was a probable suicide.

In the Republic of Ireland, a coroner determines whether a death is a suicide and records that decision on the death certificate. The validity and reliability of certifications of suicide are decreased for several reasons. The determination of suicide requires that the death be established as both self-inflicted and intentional beyond reasonable doubt. For most coroners, establishing intentionality is the most difficult criterion. A coroner who suspects suicide may be reluctant to impose social stigma, guilt, and potential loss of insurance benefits on the victim's family. Since many coroners lack explicit criteria for assessing suicidal intent, they might search for a narrow range of evidence concerning intent, principally in the form of direct communication such as a suicide note. Thus, it might be concluded that a death was not a suicide because information proving intent

Figure 2: SSIS-PAM - Access to multiple sources of information



was not collected. However, absence of evidence of intent is not evidence of absence of intent. Death certificates are the primary data source for determining mortality statistics. Therefore, public health priorities are influenced considerably by the coroner's response to these issues. Thus, underreporting of suicide can affect research, prevention, and intervention efforts. More accurate reporting may improve understanding of the risk factors for suicide and lead to more effective prevention strategies.

To address these problems, Rosenberg *et al* (1988) developed criteria for determining suicide in the absence of indisputable evidence. These operational criteria may improve reporting by helping to standardise how information is collected, collated and incorporated into the manner of death determination. The coroner is more likely to identify a suicide correctly when the case file contains objective information regarding intent to die.

The criteria are as follows:

Self-Inflicted: There is evidence that death was self-inflicted. This may be determined by pathological (autopsy), toxicological, investigatory, and psychological evidence and by statements of the decedent or witnesses.

Intent: There is evidence (explicit and/or implicit) that, at the time of injury, the deceased intended to kill himself/herself or wished to die and that the deceased understood the probable consequences of his/her actions. This evidence may include:

Explicit verbal or nonverbal expression of intent to kill self; implicit or indirect evidence of intent to die, such as preparations for death inappropriate to or unexpected in the context of the decedent's life, expression of farewell or the desire to die or an acknowledgment of impending death, expression of hopelessness, expression of great emotional or physical pain or distress, effort to procure or learn about means of death or to rehearse fatal behaviour, precautions to avoid rescue, evidence that decedent recognised high potential lethality of means of death, previous suicide attempt, previous suicide threat, stressful events or significant losses (actual or threatened), or serious depression or mental disorder.

Using the recommendations of Rosenberg *et al* (1988) as a template for consideration of inclusion, data to this point has been gathered pertaining to 34 individuals who died while on the caseload of the Donegal Mental Health Service. As the amount of information on each case varied considerably, it was considered necessary to rate each service user as:

- Highly likely to be a suicide (22 cases): Classified A
- Probably a suicide in the presence of recorded prior behaviour (9 cases): Classified B
- Doubt remaining as to suicide but with previous recorded suicidal behaviour (3 cases): Classified A/B

PROCEDURE

Cases were considered for inclusion if the death of a Donegal mental health service user was classified as a 'suicide or sudden untimely death' during October 2011 and May 2015. As agreed with the study Steering Group, a senior representative of the Psychiatric Services in Letterkenny Psychiatric Unit initiated contact with next of kin. Contact was followed by a stepped approach designed to facilitate support for families bereaved by suicide and sudden death, while simultaneously generating a profile of the deceased and their progression through services as both inpatient and outpatient.

FACILITATION OF SUPPORT

The Senior Research Psychologist (SRP) facilitated support for families bereaved by suicide or sudden unexpected death. The first contact between the SRP and a bereaved family member was made following telephone contact by the senior representative of the Letterkenny Psychiatric Services during which the bereaved family member gave permission to be contacted by the NSRF. This was followed by a letter from the Letterkenny Psychiatric Services and the NSRF introducing the remit of the study and informing the next of kin that the SRP from the National Suicide Research Foundation would make contact by telephone within 10 days. A refusal slip was included, on receipt of which no further contact would be made (see Appendix 1). Within the time frame, telephone contact was initiated by the SRP who used this opportunity to assess the needs of the family in relation to appropriate support.

FOLLOW UP/REFERRAL TO OTHER AGENCIES

If required, the SRP subsequently liaised with representatives from an appropriate bereavement support or related service who would be available to provide support to bereaved families in the Donegal region. Additionally, a bereavement support pack with details of such services was posted to family members who agreed to receive such a pack. This was followed by a letter of confirmation from the NSRF (see Appendix 2). In situations where family members expressed a preference to receive follow-up phone calls, this was always facilitated by the SRP.

INFORMATION/RESEARCH

In addition to the proactive facilitation of support, the psychological autopsy method is used to achieve better knowledge and understanding of factors contributing to the occurrence of suicide. A key component of the Suicide Support and Information System Information (SSIS) is its capacity to collect information from multiple sources which can be verified and representative of a standardised data capture format (Table 3). This provides clarity for research and analysis of data pertaining to individual suicides thus minimising potential for interpretative bias.[2]

Data is gathered from four sources:

- Medical records
- Health Care Professional Questionnaire – General Practitioner
- Relative/Informant Interview
- Coroner's records

Following facilitation of support, the SRP invited a family member who had a close relationship with the deceased to participate in a semi-structured psychological autopsy interview. Participation in the interview was on a voluntary basis and the family member could decide to end the interview at any time. If a family member expressed a preference to participate in the interview together with another family member, every effort was made to accommodate such an arrangement. The venue was selected by the participant.

Following completion of the interview with family members, permission was sought to contact the General Practitioner who had been in contact with the deceased prior to death. Subsequent to agreement, a semi-structured questionnaire was sent to the GP along with a letter outlining the study, its origins and objectives (Appendix 3). The final research phase involved examination of the coronial files of the deceased to obtain information regarding post-mortem findings and toxicology reports.

[2] The SPSS PAM model will continue in County Donegal with plans for implementation in other counties in Ireland.

THE FAMILY INFORMANT INTERVIEW

The psychological autopsy method is recognised as a suitable method for research involving next of kin. Research shows that despite presenting a challenge to the family member, many experience a beneficial effect from participation (Beskow *et al*, 2007). The psychological autopsy model can be helpful by presenting an opportunity to find meaning in the suicide, and offers the bereaved an opportunity for altruistic participation while benefiting from psychological support. Often, it provides the sole opportunity for reflection and disclosure of feelings which may be perceived by others as negative and resentful. This is particularly the case when contact is structured, such as the SRP making personal contact and following up with a letter, as well as providing a bereavement pack to those interested (Hawton *et al*, 2003).

INTERVIEW DURATION

Interviews lasted approximately three hours and in some cases it was necessary to arrange a second appointment.

ETHICAL CONSIDERATIONS

The SSIS-PAM proposal was approved by the Letterkenny Hospital Clinical Research Ethics Committee. Confidentiality for those taking part in the study as well as the deceased, was ensured in a number of ways. Before participating in the interviews, family informants were provided with information on the study and completed a consent form (Appendix 5). In the event of a refusal, approval was provided for examination of the clinical records of the service user.

DATA PROTECTION AND CONFIDENTIALITY

Confidentiality is strictly maintained. The National Suicide Research Foundation is registered with the Data Protection Agency and complies with the Irish Data Protection Act of 1988 and the Irish Data Protection (Amendment) Act of 2003. Only anonymised data are released in aggregate form in reports. Data was securely stored, passwords were encrypted and all sensitive information was filed on the secure NSRF server. Names and any other identifiable characteristics such as address details were substituted with numeric codes. Computer equipment was securely stored in a locked facility when not in use.

DATA ANALYSIS

The data was exported from the SSIS-PAM database into IBM SPSS for statistical analyses. Data was obtained from medical records and where possible from family informants for 34 cases and the completed semi-structured questionnaires obtained from health care professionals were available for 13 cases. Frequencies were calculated for all data items. Statistically significant differences between groups were examined using Chi-square tests for categorical variables and t-tests for continuous variables. Differences were considered to be statistically significant if their associated p-value was <0.05. In accordance with confidentiality guidance for reporting health statistics, values less than 5 are not reported (ONS, 2006).

Table 3: Multi-source data optained by SSIS-PAM

DATA RETRIEVED FROM CLINICAL RECORDS	CORONER'S RECORDS	HEALTH CARE PROFESSIONAL QUESTIONNAIRE	RELATIVE/INFORMANT INTERVIEW
Assigned ID	Assigned ID	Assigned ID	Assigned ID
Address Information	Address Information	Address Information	Address Information
Gender	Gender	Gender	Gender
Age	Age	Age	Age
Sexual orientation	Sexual orientation	Sexual orientation	Sexual orientation
Living arrangement	Living arrangement	Living arrangement	Living arrangement
Marital Status	Marital Status	Marital Status	Marital Status
Presence of children	Presence of children	Presence of children	Presence of children
Employment Status	Employment Status	Employment Status	Employment Status
Employment Sector	Employment Sector	Employment Sector	Employment Sector
•	Education Level	Education Level	Education Level
•	Criminal History	Criminal History	Criminal History
GP Details	GP Details	GP Details	GP Details
Health Card Provision	Health Card Provision	Health Card Provision	Health Card Provision
Prescribed Medication	Prescribed Medication	Prescribed Medication	Prescribed Medication
Pharma-compliance	Pharma-compliance	Pharma-compliance	Pharma-compliance
Menopausal Stage (Female)	Menopausal Stage (Female)	Menopausal Stage (Female)	Menopausal Stage (Female)
Death Classification	Death Classification	Death Classification	Death Classification
Method of Suicide	Method of Suicide	Method of Suicide	Method of Suicide
Communication of Suicidal Intent	Communication of Suicidal Intent	Communication of Suicidal Intent	Communication of Suicidal Intent
Previous Self-harm Behaviour	Previous Self-harm Behaviour	Previous Self-harm Behaviour	Previous Self-harm Behaviour
Diagnosed Physical/ Mental Health Conditions	Diagnosed Physical/ Mental Health Conditions	Diagnosed Physical/ Mental Health Conditions	Diagnosed Physical/ Mental Health Conditions
Known Substance Use/ Abuse/Dependence	Known Substance Use/ Abuse/Dependence	Known Substance Use/ Abuse/Dependence	Known Substance Use/ Abuse/Dependence

4. Findings

4.1 RESPONSE

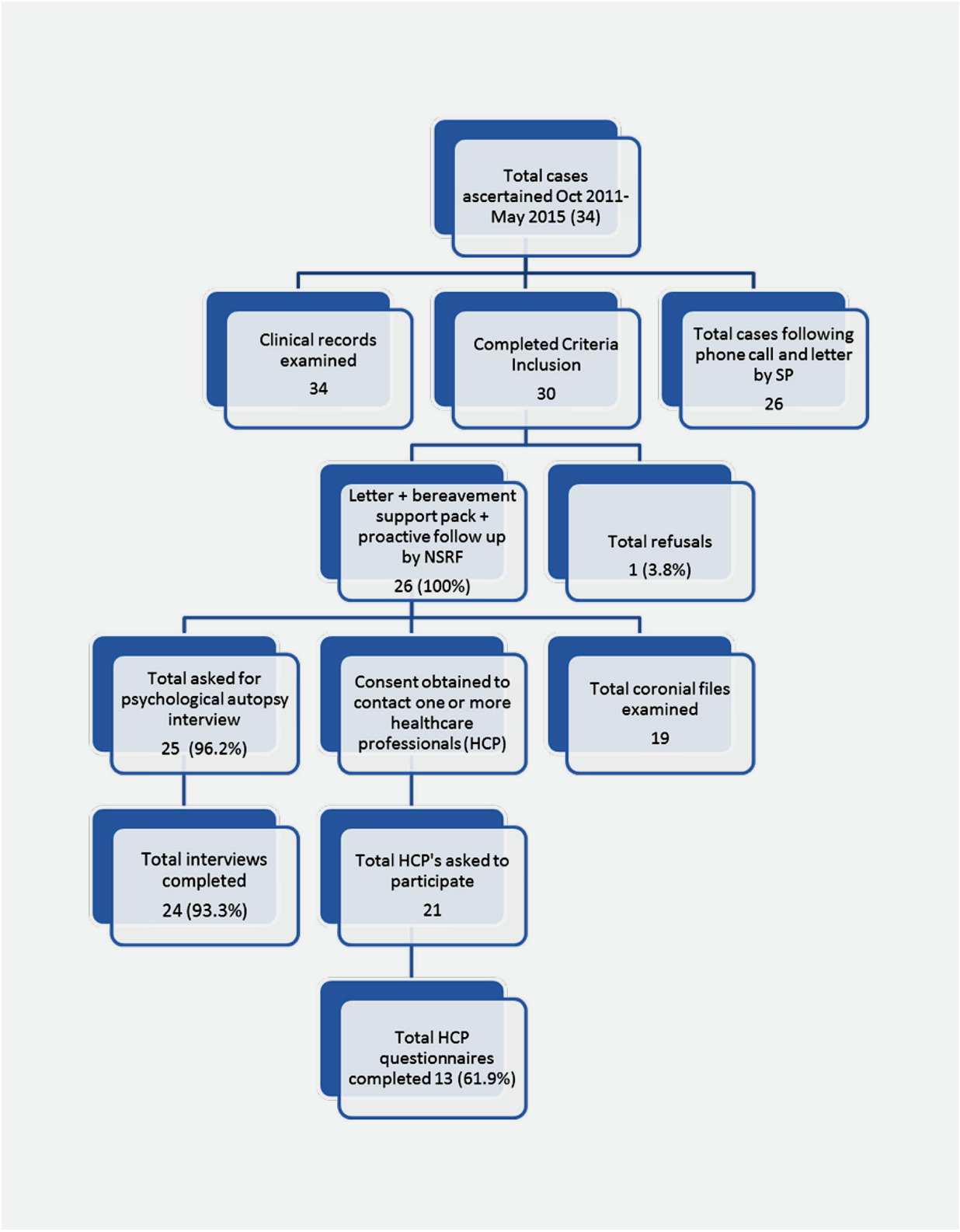
The initial sample comprised 26 consecutive cases of suicide and probable suicide cases involving people who were in the care of the Donegal Mental Health Service between October 2011 and May 2014. Due to the proximity of the fatal event, 8 additional cases that occurred up to May 2015 were later added, amounting to a total number of 34 cases (Figure 3). The 8 cases did not meet the time-threshold criteria to initiate and approach family members, agreed to be four months post bereavement. However, their information was included from the clinical records and these families will be contacted at a later date.

Family informants who were asked to take part in the study of their experience of the deceased's service history were selected on the basis of having been listed as next of kin in medical records pertaining to the deceased. Contact details were unavailable in 2 cases. At the first point of telephone contact by a senior psychiatrist, 2 potential participants declined, reducing the pool to 26. However, both participants agreed to be contacted at a later date. Of those remaining, one person declined following contact by the SRP, and a further family member withdrew consent on the day of the interview.

It was decided by the research team that the demographic and clinical characteristics of two of these would be included in any case, in accordance with established ethical protocol. In total, 26 cases were included and 24 interviews were conducted, representing a response rate of 92.3%, a figure well in excess of comparative international research programmes.

Contact with General Practitioners involved in the care of the deceased was contingent on family permission following interview. A total of 21 families gave the necessary consent. Response rates were lower among General Practitioners, with two thirds of the questionnaires being returned (n=13, 61.9%). Due to a change of Coroners and the fact that the coronial inquest had not been completed for a number of cases, it was not possible to complete this part of the information gathering process (n=15 cases remaining), although plans are in place to address this at a later date.

Figure 3: Flowchart illustrating flow of cases and response rates through the SSIS-PAM



*By subsequent agreement with the steering group a further eight cases of suicide beyond this time frame (until May 2015) were added to the existing sample, thus increasing the overall sample to 34 people.

4.2 SOCIO-DEMOGRAPHIC FACTORS ASSOCIATED WITH SUICIDE

Between October 2011 and May 2015, 34 suicides or sudden untimely deaths occurred among users of the Donegal Mental Health Service. Inclusion criteria are outlined in detail in the methods section of this report.

GENDER AND AGE

Among those who had died by suicide, there was a higher number of men (n=23) than women (n=11), which is in line with the national gender balance among people who die by suicide. However, in the present study, the number of women was higher compared to the national gender ratio (CSO, 2014).

The mean age for men (m=41.1 years, SD 13.5) was significantly lower compared to women (m=44.0 years, SD 15.5). The age range among men was 21-67 years, and for women this was 20-63 years.

LIVING ARRANGEMENTS

The majority of the deceased either lived alone (n=14), with their spouse or in a co-habiting relationship (n=8). A distinction was made between those who were either married or co-habiting as it is generally accepted as a marker of the cultural landscape, in which many people choose not to formalise their relationship. Of the remaining, 10 lived either with parents in the family home or with adult children. A small number of the deceased lived in temporary accommodation. Among the deceased, 13 had between one and three biological children.

MARITAL STATUS AND LIVING ARRANGEMENTS

At the time of death, more than two thirds of those who died by suicide (n=24) were single (including separated or divorced), 6 were married and the remainder were cohabiting or widowed.

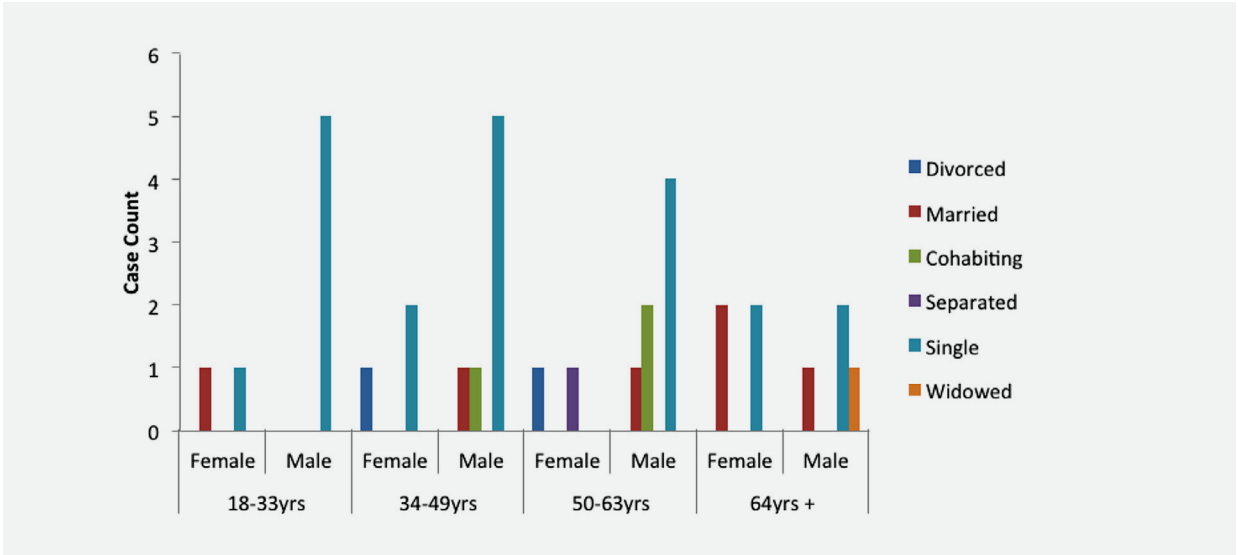
EMPLOYMENT STATUS

In terms of employment status, 71% of the deceased (16 males, 9 females) were unemployed at the time of death. A further 14% (n=5) were in employment, including those who were off work on sick leave, with students and those who were retired accounting for the remaining 15% (6% and 9% respectively).

EDUCATION

Overall, 28 of the deceased had achieved a Junior Certificate level of education, including 12 males. Of these, 13 had progressed to Leaving Certificate level (six males, seven females). The remainder had learned a trade, and were enrolled in or had completed third level education at time of death.

Figure 4: Measure of isolation of deceased



RELIGION

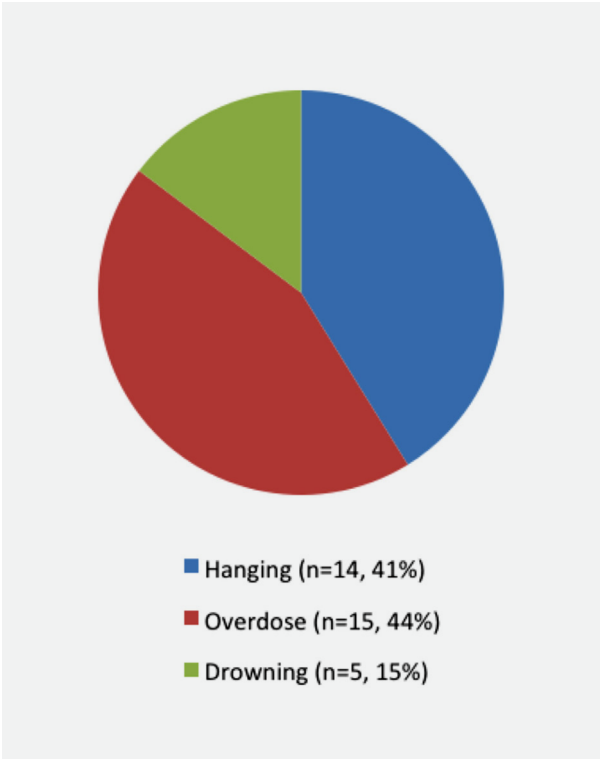
With regard to religion, the majority of the deceased were Roman Catholic 91% (n=31). Of these, 11 were female and 20 were male. Those remaining followed other religions.

4.3 CHARACTERISTICS OF SUICIDE AND UNTIMELY SUDDEN DEATHS

METHOD OF SUICIDE AND UNTIMELY SUDDEN DEATHS

The largest number of fatalities occurred following intentional overdose of medication, either prescribed, over the counter or illicitly obtained (n=15). Suicide by hanging was also proportionately high (n=14), while the remainder died by drowning (n=5). When examined by gender, the majority of women died by intentional overdose (n=7) and over half of men died by hanging (n=12) followed by intentional overdose.

Figure 5: Method of suicide and untimely sudden deaths



LOCATION

Approximately 30% of all deaths occurred in the area of Letterkenny Town (n=10). Two deaths were recorded in the Kilmacrenan area; closer enquiry revealed that both deceased were friends and died within 10 months of each other.

MONTH OF DEATH

Most of the deceased died during winter, comprising December, January and February (n=13) and spring comprising February, March and April (n=12). No fatalities were reported in August of any full years being examined (2011-2014). A relatively low number of deaths were recorded during the summer season (<5). The highest number of deaths took place in winter and spring of 2012/2013, with 5 tragic events taking place at each calendar point.

Table 4: Seasonal variation

Month	Season	Total
December	Winter	13
January		
February		
March	Spring	12
April		
May		
June	Summer	<5
July		
August		
September	Autumn	5
October		
November		

DISTANCE FROM EMERGENCY CARE

A relatively large number of the deceased (n=11) were between 50 and 65 km away from Letterkenny General Hospital (LGH) when they died (n=11). Five fatalities occurred between one and five kilometres from emergency care. Figures 6 and 7 illustrate both distance and time from the emergency department LGH prior to death.

Figure 6: Distance from emergency care at time of death

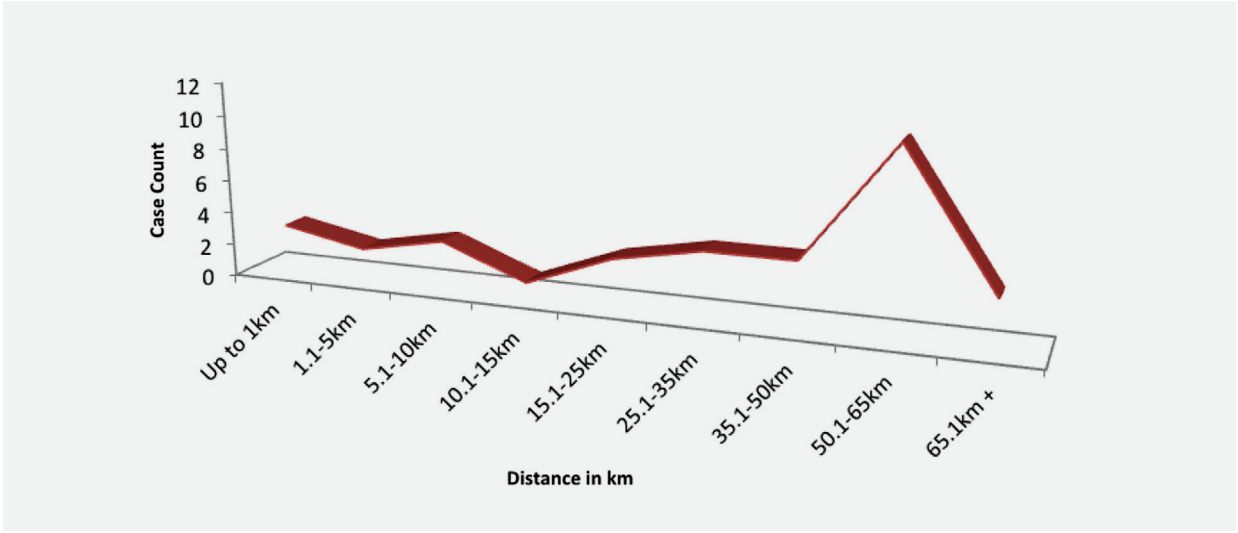
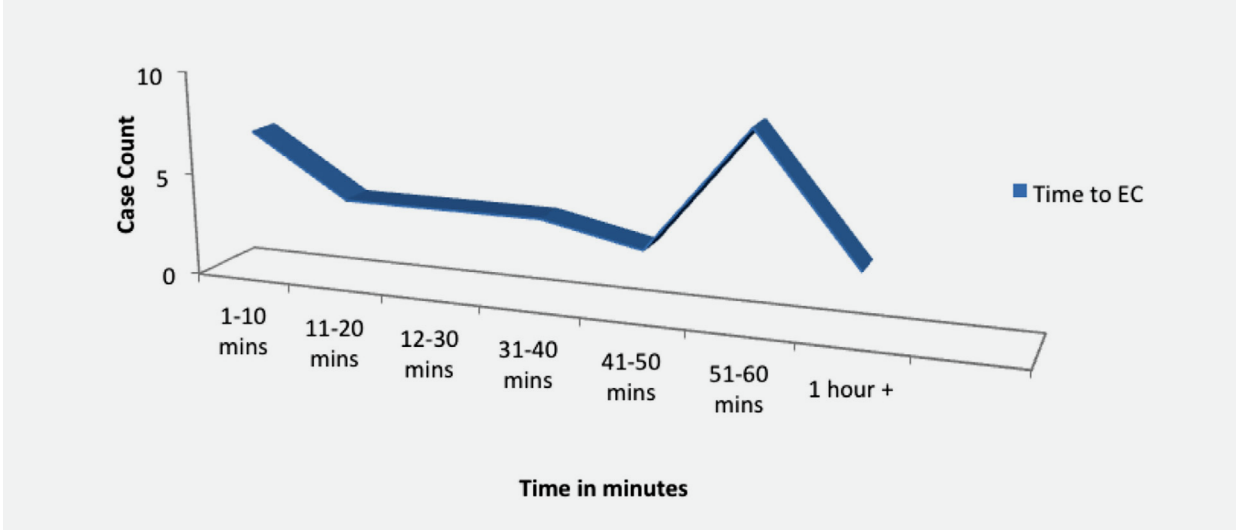


Figure 7: Driving time in minutes to emergency care



4.4 PSYCHOSOCIAL AND PSYCHIATRIC CHARACTERISTICS

PRECIPITATING FACTORS IN THE MONTH PRIOR TO SUICIDE

Considering precipitating factors in the month prior to suicide, the experience of significant loss(es) was most frequently reported. Loss(es) mostly involved loss of a relationship, family members or friends, prestige and finances. Other frequently reported factors included significant (or perceived) disruption of a primary relationship, significant life changes (either negative or positive), legal troubles or difficulties with the Gardai, experience of a (perceived) traumatic event and anniversary of an important death.

HISTORY OF SELF-HARM

A history of self-harm was known for 26 cases. Among those known to have engaged in previous self-harm, almost half (n=12) had undertaken at least one self-harm act and the remaining 14 had reportedly engaged in between three and 11 intentional self-harm acts. In terms of method of self-harm, 15 had engaged in intentional drug overdose and 11 had engaged in attempted hanging, drowning or a road traffic accident. With regard to the time lapse between last act of self-harm and death by suicide, 17 of the deceased had engaged in self-harm within the 12 months prior to ending their lives. Of these, <5 had engaged in self-harm in the two days before they died.

SUICIDAL BEHAVIOUR BY PERSONS KNOWN TO THE DECEASED

Of those who died by suicide, 15 had experienced suicidal behaviour (fatal or non-fatal) of persons known to the deceased. Of these 15 people, the majority (n=11) had experienced suicidal behaviour of a friend, a fellow drug user, or a fellow patient.

FAMILY HISTORY OF MENTAL HEALTH ISSUES

Among the deceased, the majority (n=18) had family members with known mental health issues, which was similar for both males and females. The most common mental health issues experienced by family members were depression and substance abuse.

ALLEGED SEXUAL ABUSE IN CHILDHOOD

A history of sexual abuse in childhood was reported for five of the deceased involving both men and women. In some cases, the deceased was both victim and perpetrator, involving other family members.

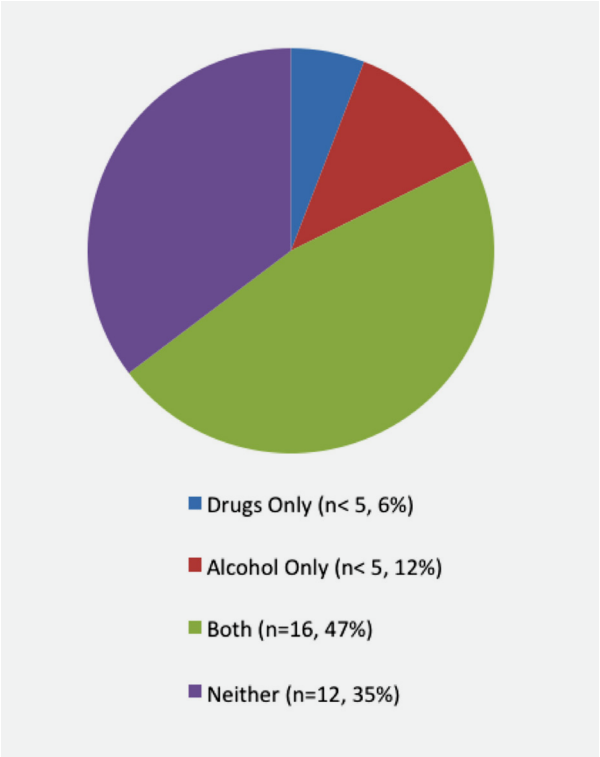
EXPERIENCE OF VIOLENCE

Among the deceased, 12 had experienced violence as a child, including the majority being males. In addition to these reported early experiences, twelve of the deceased (52.17%) had a history of violence as an adult, the majority (n=10) being males.

KNOWN SUBSTANCE ABUSE

SSIS-PAM enquires about the known drug and alcohol use of each case. In addition to information obtained from clinical records, family informants provided relevant information regarding the observed behaviour of loved ones, supported by GP response to the Health Care Professional questionnaire when available. Almost half of the deceased were known to abuse both drugs and alcohol at the time leading to death (47%, n=16). Of these, the majority were male (n=12). A further six persons were known to abuse either drugs or alcohol singularly.

Figure 8: Reported substance abuse of the deceased



SLEEP DISTURBANCE

For 13 of the deceased a significant sleep disturbance was reported either in clinical notes or by the family informant, including seven men and six women.

OVERCROWDING IN CHILDHOOD

For 13 of the deceased, overcrowding in the family home during childhood was reported, operationalised as more than eight siblings per household, comprising eight males and five females.

Table 5: Total LGH psychiatric admissions by quartile from 2011 to 2014

YEAR	SEASON	M (VOL)	M (INV)	F (V)	F (INV)	TOTAL
2011	Jan-March	58	7	58	3	
	April-June	56	5	54	4	
	July-Sept	54	7	59	5	
	Oct-Dec	61	17	46	8	
Total		**229**	**36**	**217**	**20**	**502**
2012	Jan-March	63	12	61	9	
	April-June	69	12	65	5	
	July-Sept	72	5	83	8	
	Oct-Dec	56	11	58	12	
Total		**260**	**40**	**267**	**34**	**601**
2013	Jan-March	62	10	58	16	
	April-June	67	8	76	18	
	July-Sept	59	7	75	14	
	Oct-Dec	61	15	58	9	
Total		**249**	**40**	**267**	**57**	**613**
2014	Jan-March	53	6	72	14	
	April-June	66	11	70	16	
	July-Sept	81	14	74	16	
	Oct-Dec	69	8	70	5	
Total		**269**	**39**	**286**	**51**	**645**

4.5 PSYCHIATRIC ADMISSIONS

TOTAL ADMISSIONS TO LETTERKENNY PSYCHIATRIC UNIT: AN OVERVIEW

During the period 2011-2014, the psychiatric unit in Letterkenny recorded a total of 2361 admissions, representing an average of 590 patients per year. It is unclear how many of these were readmissions rather than initial presentations due to variability in the recording of patient status. Table 5 provides details of these admissions on a quarterly basis. Total admission rates have remained comparatively stable for males during this period relative to females, where increasing rates can be seen each year, particularly with regard to involuntary admissions. With the exception of 2012, the highest rates of male admissions took place in the latter quartiles, whereas females were admitted most often in the mid quartiles. Hospital figures show a 28% increase in overall admissions from 2011 to the end of 2014, a rate which is rising annually.

SEASONAL VARIATION

Figure 9 provides a graphical illustration of overall quarterly admissions during the four year period. By using 2011 as the baseline with the lowest proportions, increasing rates are clearly demonstrated, peaking in the mid-quartiles of 2013 and 2014. This is also the point at which the highest overall rates are recorded by women. It can be observed that until 2014, rates of psychiatric admissions were lower in the first and last quartiles of each consecutive year.

Figure 9: Total overall psychiatric inpatient admissions in LGH 2011-2014

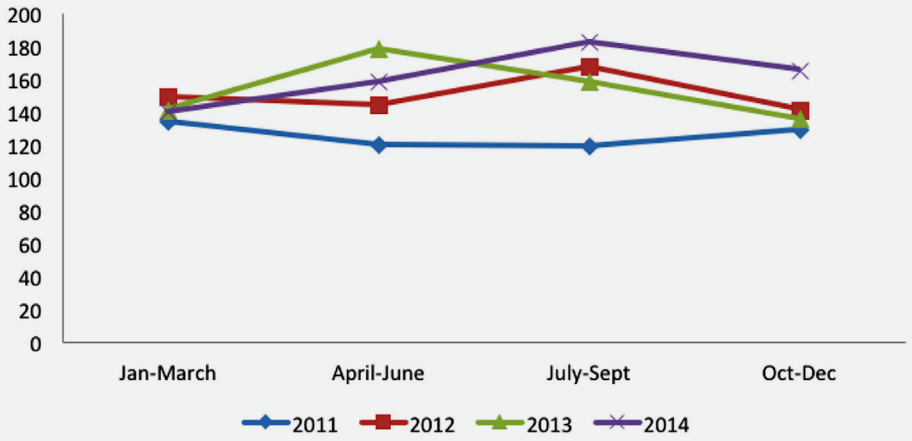
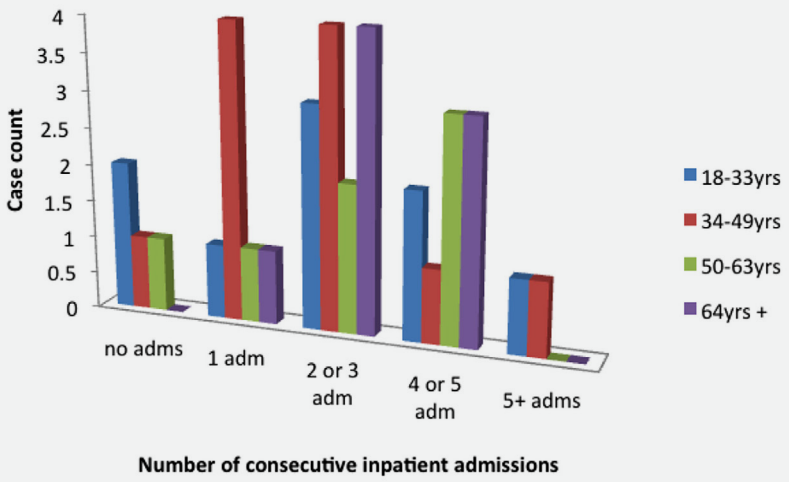


Figure 10: Age proportions of now deceased psychiatric admissions



ADMISSION PROFILES OF THE DECEASED INCLUDED IN THE CURRENT STUDY

Inpatient psychiatric admissions ranged from 0 to 15 occasions among the deceased, with three service users treated solely as outpatients in combination with private psychiatric care. The remaining 31 had a history of at least one voluntary or involuntary inpatient psychiatric admission, with the majority of these being admitted two to three times prior to death (Figure 10), including occasions when voluntary status was revoked due to deteriorating mental health, fear of absconding, or perceived danger to self or others. The majority of cases presented to Accident and Emergency in a suicidal state and were accompanied by concerned family members. A significant proportion of these (22.6%, n=7) disclosed information pertaining to previously unreported incidents of self-harm during the assessment process. While similar rates were observed throughout the age cohort, those in the younger age groups (18-34 years and 34-39 years) had higher rates of multiple admissions relative to their older counterparts. Patients aged between 34 and 49 years had the highest number of overall admissions while those aged 50- 63 years had the least. A small number of cases (<5) with more than 5 admissions were aged between 18 and 49 years, with a combined total of 25 occasions when inpatient care was deemed necessary including involuntary admissions due to perceived risk to self or family members.

TIME BETWEEN LAST SERVICE CONTACT AND DEATH

For purposes of analysis, service use is operationalised as available services within Donegal Mental Health Service following discharge from an in-patient setting, including out-patient psychiatry, community mental health, addiction treatment, occupational therapy, child and family services and social work. <5 of the 34 deceased had no history of psychiatric admission, but did attend outpatient services. Similarly, <5 of those who had previously been psychiatric inpatients declined outpatient services on their discharge. Of the remaining 28 cases <5 of these died while on day leave from the psychiatric unit and <5 were in telephone contact with their Community Mental Health Team in the hours prior to death. Only one of the four was considered to be at significant suicidal risk and had been in regular contact with services following discharge from the psychiatric unit a year previously.

Overall, outpatient treatment was subject to repeated instances of non-attendance by more than three quarters of service users. Often they or someone on their behalf made contact shortly before the allocated time; on many occasions the service user simply failed to attend. It is commendable that service to service user outreach was consistent and re-engagement diligently sought by those mental health professionals involved. Contact was made via telephone and letter offering further appointments on approximately 3 occasions following disengagement. After this, the offer of service was withdrawn on the understanding that contact could be re-established by request in the event of relapse.

INPATIENT DISCHARGE PRIOR TO DEATH

A total of six deaths occurred between 24 hours and four weeks post-discharge from the psychiatric unit, including occasions of temporary leave, designed to encourage service users to reintegrate themselves with family and friends prior to discharge from the unit. Four of these deaths occurred among the cases added later which took place 2014/2015. This number peaked between three and nine months post discharge with 8 deaths taking place during this period. Almost half (n=14) of the deceased died at least one year following psychiatric discharge. Of these, 20% (n=6) had not been admitted to psychiatric care for at least three years prior to death (Figure 11).

SERVICE DISENGAGEMENT PRIOR TO DEATH

Unless the patient specifies no further contact, it is normal process that they are referred onwards to outpatient services following inpatient discharge. Three of the total 34 deaths being examined had chosen not to act on referral at this point. Thirteen deaths (42%) took place between one day and four weeks post service engagement, with a further 10 fatal events (32%) from this point up to 2 months following contact. A decrease was observed in the period between 3 and 6 months following disengagement (n=6) (Figure 12).

Figure 11: Discharge timeline for post-inpatient deaths

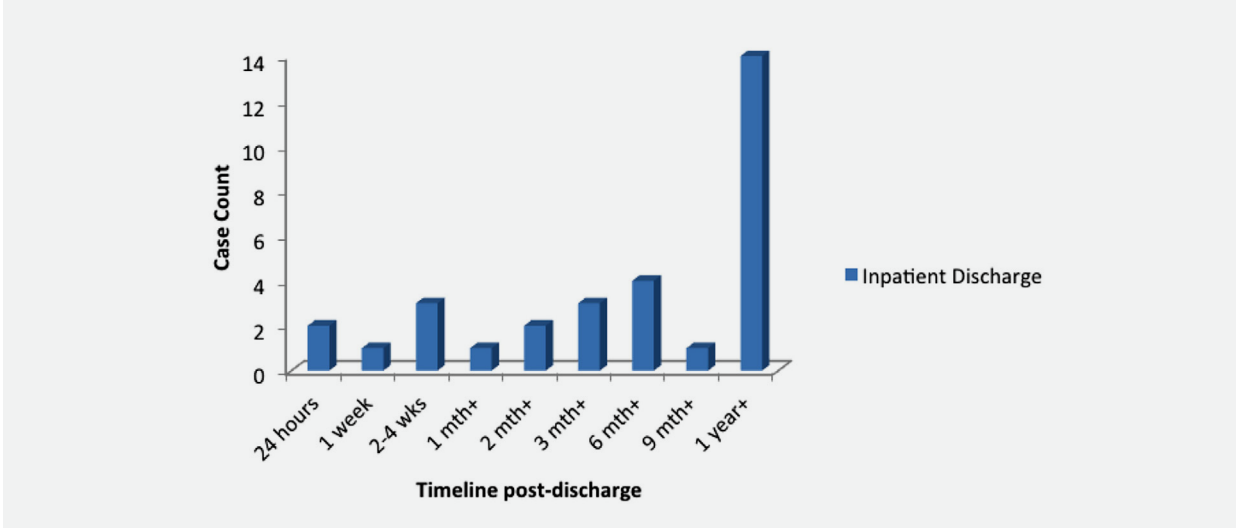


Figure 12: Outpatient timeline prior to death

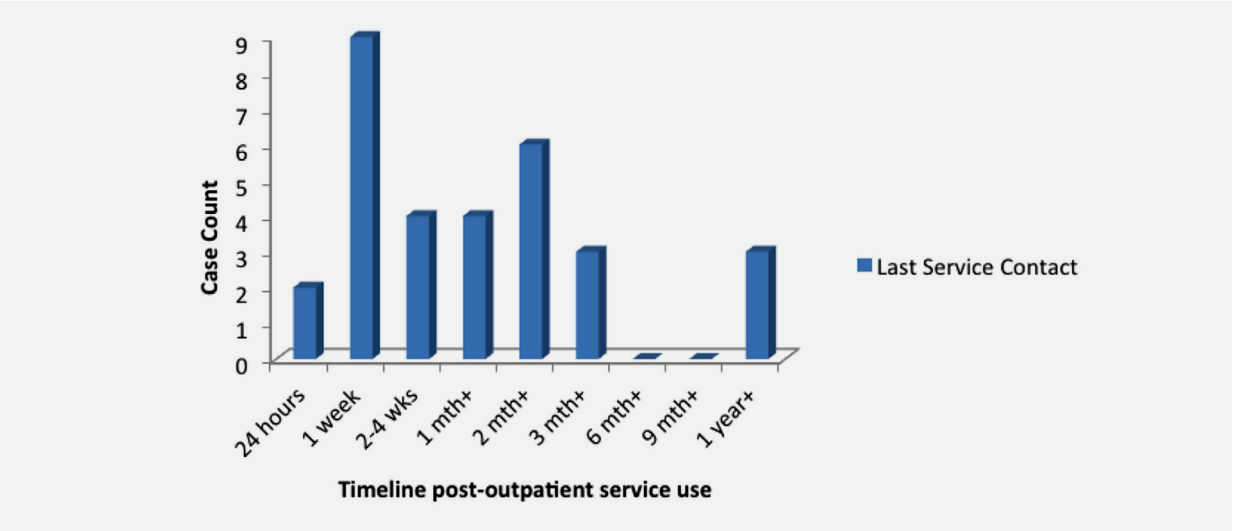
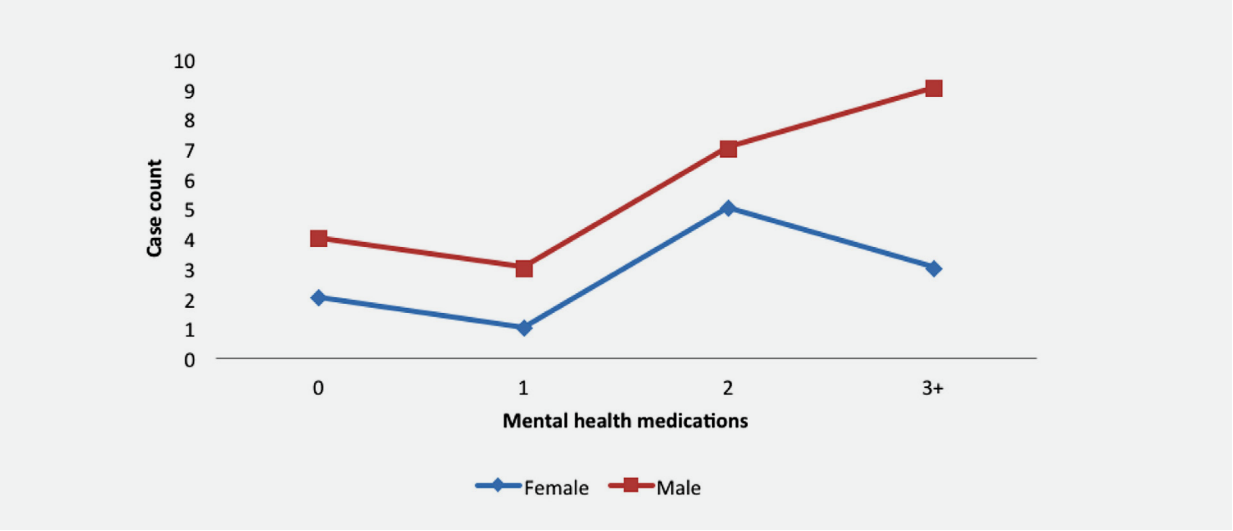


Figure 13: Mental health medication prescribing among the deceased



4.6 PRESCRIBING, COMPLIANCE AND PSYCHIATRIC DIAGNOSIS

PRESCRIBED MEDICATION AND GENDER

The majority of the deceased (n=28, 82%) were being prescribed medication for mental illness preceding death. Of these, 19 were male and 9 female. Of the remaining cases, males were twice as likely to have had no medication prescribed for mental health issues relative to females. Figure 13 demonstrates a similar pattern with regard to multiple medications, with three times as many males being prescribed three or more mental health medications.

Overall, there was an equal gender distribution with regard to prescribed medication for physical health issues (m=8, f=7) with females more frequently diagnosed with digestive complaints and prescribed multiple medications (Figure 14). Males and females were prescribed pain medication equally (n=8), while almost four times as many males were not being prescribed any medication for physical illness at time of death.

PRESCRIBED MEDICATION AND AGE

Overall, the highest rates of prescribing for mental illness occurred in the mid-range of 34-49 years. Deceased service users aged between 34 and 39 years and those aged 50-63 years had the highest rates of non-prescribing, with deceased in

Figure 14: Physical health medication prescribing among the deceased

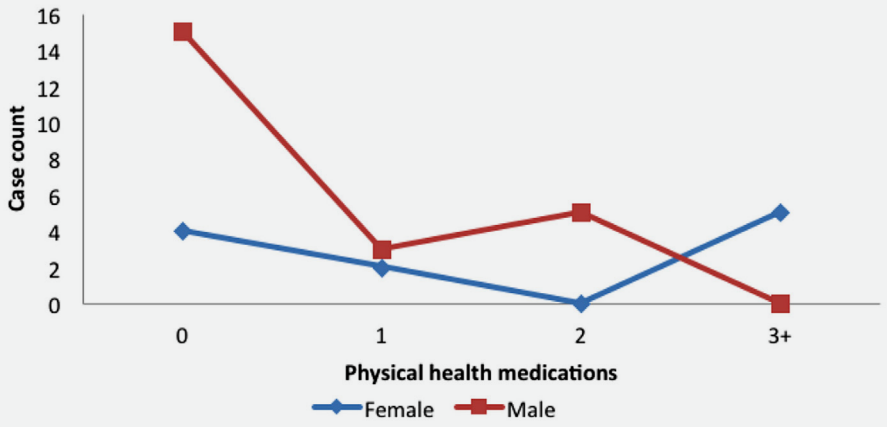
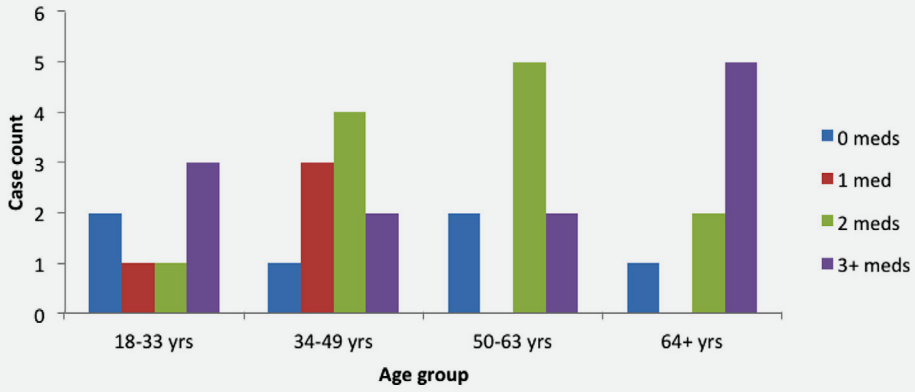


Figure 15: Mental health prescribing by age



the older age categories being prescribed two or more medications for mental ill health (Figure 15). The group comprising those aged 64 and above demonstrated the upper level of prescribing (three or more separate mental health medications), as did those aged 50-63 years, who had the highest rate of two prescriptions.

COMPLIANCE WITH PRESCRIBED PSYCHOTROPIC MEDICATION

In 28 of the 34 cases examined, 82% (n=28) were being prescribed psychotropic medication at time of death. These medications were examined under the headings of anti-depressants, antipsychotics, sleep aids, anxiolytics and benzodiazepines. The World Health Organisation 2003, cited in Brown *et al*, 2011 estimates that approximately 50% of those with a diagnosed chronic illness are likely to demonstrate non-compliance with their medication regime. In general, compliance was lower in County Donegal (n=21, 62%) regardless of gender and age, primarily determined through clinical records and corroborated where possible by the GP, coronial files and the psychological autopsy interview with family members of the deceased. Information included reckless behaviour such as hoarding large supplies while requesting repeat prescriptions, and selling or exchanging prescribed medication for illegal drugs. Non-compliance remained an issue when considered in terms of age and gender.

ANTIDEPRESSANTS

Half of the deceased (n=17) were being prescribed antidepressants in the year prior to death, representing an equal gender balance. Less than one quarter were noted as being compliant with medication. Regardless of age-group, the majority (n=7) of females were non-compliant with prescribed antidepressants. An increase was observed in male compliance with one third (n=6) described as maintaining their drug regime, particularly in the mid to older age range of 34-63 years.

ANTIPSYCHOTICS

Over one third of the deceased (n=13) were using antipsychotic medication at time of death, mostly males. The majority of cases (n=10) had noted non-compliance.

HYPNOTICS

Of the total 34 cases under examination, over a quarter (n=9) were being prescribed sleep aids. Overall, 5 of the nine individuals were considered compliant.

ANXIOLYTICS

Similar to sleep aids, nine of the total cases were taking anxiolytic medication up to and at time of death. The vast majority of these were male (n=8, 88%). Of the remaining cases, compliance was observed in <5 and found in the youngest (18-33 years) and oldest (64 years plus) age groups.

BENZODIAZEPINES

Sedatives such as diazepam were prescribed to 23.5% of the deceased, with males three times more likely to take medication of this nature relative to females (m=6, 75%, f=2, 25%, respectively). None of the females were noted as being compliant while compliance was demonstrated in males aged 34-49 years (n=1) and 64 years plus (n=1).

PRESCRIBED MEDICATION AS MEANS OF SUICIDE

Nearly half of the deceased died by intentional overdose (n=15). In the majority of cases (n=12) this involved prescribed medication, with 10 cases also involving toxicology results indicating substantial amounts of alcohol in both blood and urine at time of death.

NON-PRESCRIBING OF PSYCHOTROPIC MEDICATION

Six service users were not being prescribed medication for mental health conditions in the period leading to death. Two thirds of these were classified as category 'A', with the remaining two cases allocated category 'B' by the study researcher (see page 21). All of these, however, had a positive psychiatric diagnosis and had previously been involved with Donegal Mental Health Service as both inpatient and outpatient. Each of the deceased had used more than one outpatient service, including psychiatry. Last point of service use ranged from five to 58 days with an average timeframe of 33 days between disengagement and death.

PSYCHIATRIC DIAGNOSES

All deceased service users had a primary psychiatric diagnosis, with 85% (n=29) also meeting criteria for a secondary disorder. A primary diagnosis of depressive disorder was observed most frequently (n=16), followed by combined schizophrenia and psychotic disorders (n=7). Substance use disorder was reported as the primary cause of mental illness in a further 6 cases. The remaining 5 cases included personality, eating and anxiety disorders. A secondary diagnosis of drug and/or alcohol abuse accounted for more than half of the deceased (n=16), followed by symptoms of anxiety (n=6). Secondary depressive disorder was recorded as the reason for 11 psychiatric admissions, followed by drug and/or alcohol abuse and combined schizophrenic and psychotic disorders (n=10, n=9, respectively) (Figure 16).

Figure 16: Primary and secondary psychiatric diagnoses among the deceased

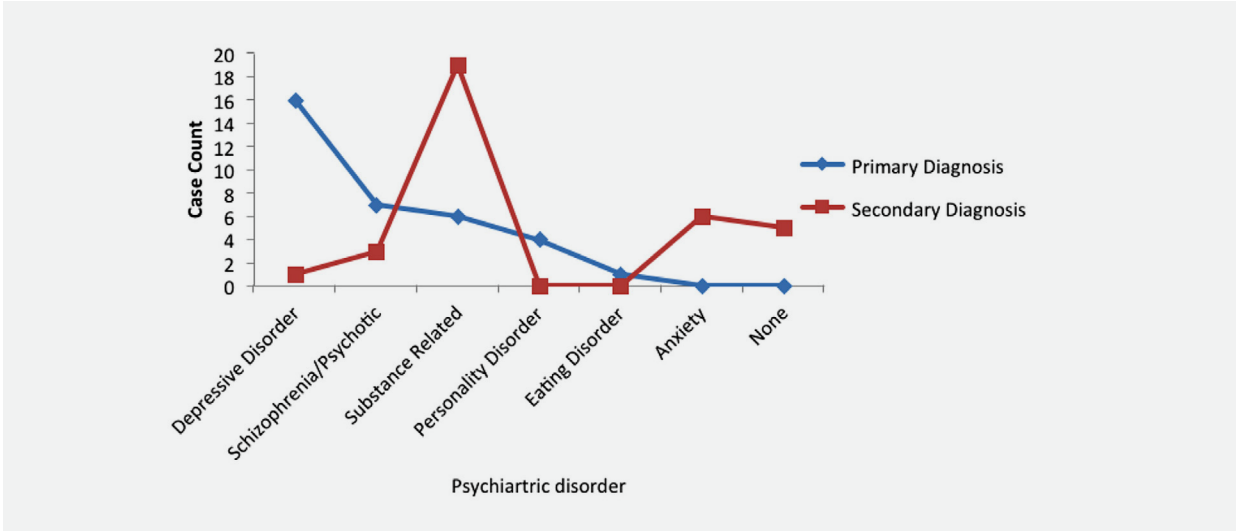
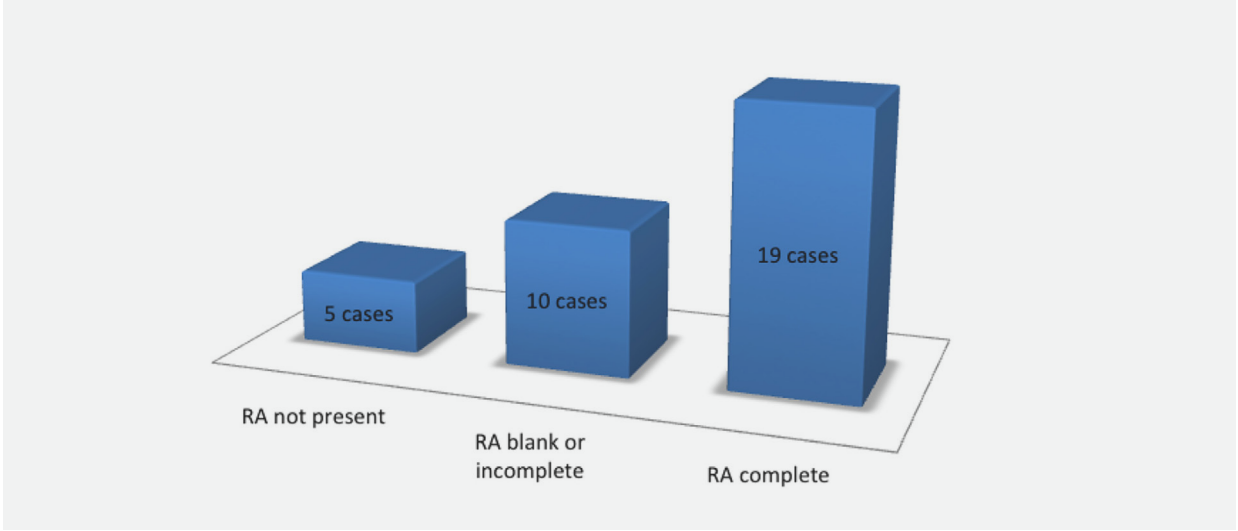


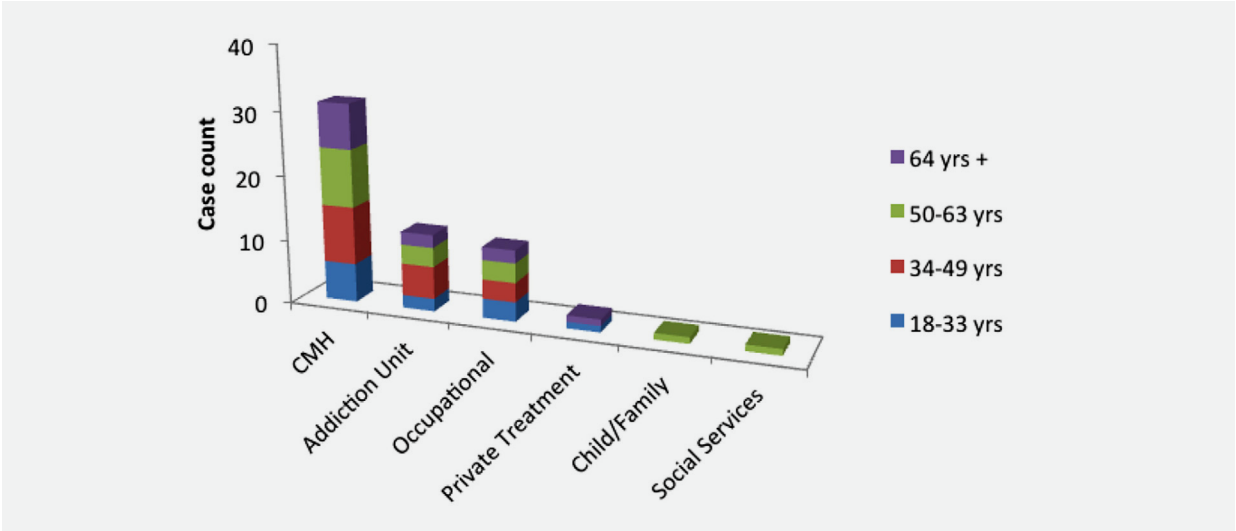
Figure 17: Staff adherence to risk recording procedure



4.7 RISK ASSESSMENT AND SERVICE ENGAGEMENT

Risk Assessment (RA) is used to evaluate the suicidal state of those who present at services with mental health concerns. Within County Donegal this is ascertained through use of the recommended Clinical Risk Assessment Form 1 (CRAM), a two page document which is completed by a clinical member of staff. This provides demographic information, details of risk indicators to self and others and an assessment of the physical and mental state of the patient. In addition, it records whether they are a current service user and lists treatment recommendations for the clinical team. This document is signed and dated by the staff member and added to the patients' notes as a guide for subsequent care. Compliance with this protocol proved variable across the sample. In five cases the risk assessment was missing from individual files, while in a further 10 cases the form was present but incomplete or blank. Some of these contained only a few words and others were illegible. In total, 44% of files contained incomplete assessments of suicidal risk, recorded in a manner too diffuse to be deemed informative of the service user's suicidal state. In the remaining 19 cases (56% of total) however, appropriate evaluation was conducted and made available in accordance with best practice principles (Figure 17).

Figure 18: Outpatient service use among the deceased



PSYCHIATRIC OUTPATIENT SERVICES

Psychiatric patients were referred to outpatient and/or social care services on discharge or following presentation. While typically remaining in the principal care of a consultant psychiatrist, these included psychiatric support through community mental health, addiction treatment, occupational therapy, child and family services and social work. In <5 cases private psychiatric treatment was engaged. All cases received support from at least one outside source at time of death, with up to 5 services involved in individual care. Over three quarters availed of two to three services (n=26). Gender and uptake of outpatient care were highly correlated, with a higher proportion of females engaging in two or three services relative to males (54.5% and 30% respectively). Those in the mid age groups between 34 and 63 years utilised a higher proportion of available services, particularly community mental health support, while cases aged 18 to 33 years and those over 64 years received the least (Figure 18).

SERVICE ENGAGEMENT, UPTAKE AND COMPLIANCE

Examination of individual files provides an opportunity to consider periods of engagement and withdrawal from services and compliance with uptake. An anonymous example of the treatment pathway of a hypothetical MHS user is illustrated in Table 6, providing a comprehensive case summary which details referrals, admissions, agency involvement, discharge and appointments the deceased failed to attend. This level of detail allows examination of the service provision and uptake of individual cases and identifies episodes of dis-engagement both by the service user and services. A significant proportion of files were incomplete, with omissions regarding individual care planning and facilitation. While letters from Consultant Psychiatry to General Practitioner were relatively consistent, sections such as occupational therapy and outside agency involvement were often missing; this proved problematic when attempting a complex analysis of movement through and between services. A lack of inter-agency communication was noted and in some cases planned follow up was unclear as notes were not available following discharge.

EXAMPLE OF THE TREATMENT PATHWAY/ SERVICE TRAJECTORY TOOL

Table 6 provides a hypothetical pathway of a deceased service user diagnosed with a primary mood disorder and secondary substance abuse disorder and multiple admissions to the psychiatric unit spanning 2007 through 2011. This individual was initially admitted following self-referral, with a further four admissions following self-referral on each occasion. The remaining two admissions were via GP referral and the NowDoc service. At each presentation, suicidal intent was expressed along with previously unreported non-fatal suicidal attempts. This trajectory provides details of increasing length of admission

during which the service user absconded on more than one occasion. A period of sustained engagement was observed in 2007 during which the person involved received multi-disciplinary care. Following discharge, a referral was made to the addiction service, which however, was unattended. Information to establish continuation of this support was not available as the notes for this period were missing from files. In 2009, there were a further two psychiatric admissions. Similarly, two admissions were recorded in 2010. Again, the service user was referred to outpatient psychiatric and multi-agency care on discharge from the in-patient unit and failed to engage with same. The final admission was in 2011, lasting for more than one week. During this admission the CASIG assessment tool was used and moderate risk of suicide or non-fatal suicidal behaviour was recorded. Clinical notes were unavailable with reference to discharge, and therefore, it was not possible to establish whether continued aftercare was provided. A relatively stable pattern of service use was established for this individual throughout the course of three years, punctuated by self-referral with clear suicidal intent. Following discharge, they were unable or unwilling to further engage with services on an outpatient basis, highlighting periods of increased vulnerability in the months post-admission and the urgency of need for close contact and intensive support during this time when potential for relapse and escalation of suicidal risk was high.

Table 6: Example of a treatment trajectory

ACTION	STATUS	DATE	DETAILS/OUTCOME	SIGNATURE AND COMMENTS
Previous psychiatric admissions	INP	Insert here	(no further details)	
Addiction unit	OP		No further details	
Self-referral to A&E	OP		Depressed state	
ADMISSION (V) Psych unit	INP		Suicidal intent and prior attempts noted	
• MDTeam meeting	INP		Referral to Addiction Unit- Urgent. Contact made with previous psychiatric facility re background	
• Psychiatric Review	INP		Medication adjusted	
Psychiatric DISCHARGE	INP		Returned to care of OPD and GP	
Self-referral to A&E	OP		Admission deemed necessary	
ADMISSION PSYCH	INP		No notes available	
Psychiatric Review	OP		DNA – Discharged to GP care	
NOWDOC Referral-ADMISSION	INP		Admission deemed necessary – 2 x Suicide attempts in 1/52 with on-going ideation and planning	
• Psychiatric Review	INP		Medication adjusted	
• Ward Meeting	INP		AU/CSA/Psych in attendance	
• 1-2-1 AU Counselling	INP		Explore level of addiction	
• Action	INP		Patient granted hours out of unit - successful	
• Psychiatric Review	INP			
• Action	INP		Referred to STEER regarding problems with current accommodation	
DISCHARGE Psych Unit	INP		Referral to Park View House (AU), OP appointment given	
Park View (AU)	OP		DNA	
Park View (AU)	OP		DNA	
Park View (AU)	OP		DNA	
Park View (AU) DISCHARGED	OP		DNA	
Psychiatric Assessment	OP		Continued engagement recommended	
Self-referral to Psych unit - ADMISSION	INP		Suicidal with persisting intent/ideation/ previous attempt	

• Psychiatric Review	INP		Plans made to revoke V status if attempts made to leave AMA	
• Psychiatric Assessment	INP			
• Psychiatric Review	INP			
• NS 1-2-1	INP		Patient requested discharge. Was persuaded to remain on unit. Revocation to IVS option revisited by Psych team should patient attempt to leave unit	
• NS 1-2-1	INP		Review of behaviour	
• Psychiatric Review	INP		1-2-1 with treating Psychiatrist	
• Action	INP		Request for daytime leave granted – on return deemed unsuccessful (alcohol taken/highly agitated)	
• Action AU	INP		Review by Addiction Unit	
• Psychiatric Review	INP		Review of medication	
• Medical Assessment in Psych unit	INP		Blood cultures/physical examination	
• Psychiatric Team visit	INP			
• Psychiatric Review	INP			
• Action NS	INP		1-2-1 NS	
• Action NS	INP		1-2-1 NS	
DISCHARGE	INP		OT/CREATE/OP/GP support	
Referral by GP – Psychiatric ADMISSION	INP		On-going suicidality/self-harm episodes	
• Action NS	INP		1-2-1 NS support and reassurance	
• Action NS	INP		1-2-1 NS support	
• Action NS	INP		NS support – patient requested leave but was persuaded to remain on unit	
• Action NS	INP		Reviewed by NS	
• Action NS	INP		Patient absconded. NS advised by psychiatric team to visit home. Patient returned willingly to ward.	
• Psychiatric Review	INP		Treatment review	
• Psychiatric Review	INP		Request for leave granted	
• Action	INP		Psychiatrist made contact with COSC	
• Action	INP		Patient returned from successful leave period	
Psychiatric DISCHARGE	INP		Requested discharge agreed	
ADMISSION	INP		On-going suicidality and depression	
• Action	INP		Risk Assessment	
• Review	INP			
• Review	INP			
• Action	INP		Did not return from agreed leave	
• Action	INP		Patient returned to unit	
• Psychiatric Review	INP		Patient requested discharge. Agreed to remain in unit	
• Psychiatric Review	INP		Referred to OT	
• Action	INP		Leave agreed for three days	
• Action	INP		Patient returned – successful leave	
DISCHARGE	INP		Discharge to care of OPD/GP/OT/COSC	
Psychiatric Review	OP		DNA	
Psychiatric Review	OP		DNA	
Psychiatric Review	OP		DNA	
Psychiatric Review	OP		DNA	
Psychiatric Review	OP		DNA	
Psychiatric Review	OP		DNA	
Self-referral A&E	OP		Absconded while waiting for psych assessment	

Psychiatric Review	OP		Review of previous year	
Self-referral ADMISSION	INP		CASIG assessment instrument used	
• Psychiatric Review	INP			
• Psychiatric Review	INP			
• Psychiatric Review	INP			
• Psychiatric Review	INP			
• Psychiatric Review	INP			
• Psychiatric Review	INP			
DISCHARGE	INP		No notes available	
No further follow up DOD Time between last service contact point and death – Insert here				

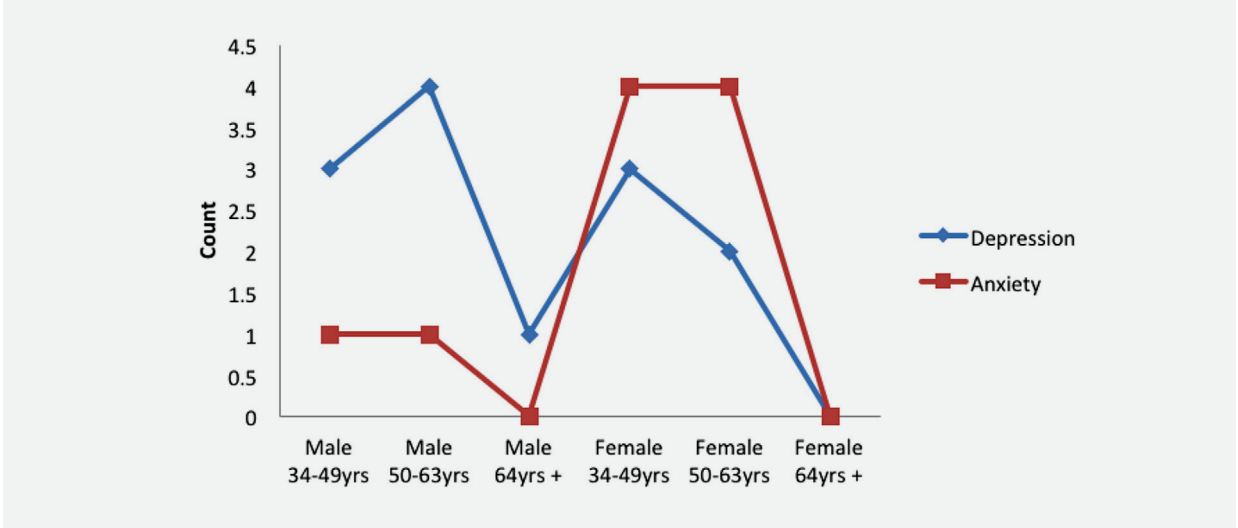
4.8 CHARACTERISTICS OF BEREAVED FAMILY MEMBERS

MENTAL HEALTH OF THE BEREAVED FOLLOWING THE SUICIDE OR SUDDEN DEATH

A total of 24 interviews were conducted in the current study, comprising information gathered from family members or other primary caregivers who had experienced the loss of a loved one by suicide or sudden untimely death. Research remains steadfast in its assertion that those bereaved under such tragic circumstances are in turn highly susceptible to suicidal thinking and behaviour and the onset or escalation of mental illness. The SSIS-PAM addresses this in a section labelled 'Informant's Wellbeing' which provides a measure of the informant's mental health status and potential risk. This section contains 21-items and permits examination of mental health by measuring anxiety and depression among the bereaved (Figure 19; Appendix 4, Page 51).

Interviews were conducted with 14 females and 10 males. All were aged over 45 years with a mean of 50.7 years and mode of 45 years (n=4). Seven females were aged between 45 and 49 years in comparison with 4 males in the same range. The remaining 7 females were aged between 50 and 63 years with five males in this group. Only one male was aged over 64 years. Males demonstrated higher levels of depression following bereavement by suicide or untimely death than females (m=8, f=5), while females had increased levels of anxiety relative to males (m=<5, f=8). All those interviewed scored on items relating to both measures. Of note, item-21 on the 'Informant's Wellbeing' section of the SSIS-PAM asks for a self-report on the statement 'I felt that life was meaningless'. A total of 16 informants endorsed this item, with seven stating 'Sometimes' and nine stating 'Often'.

Figure 19: Mental health measure of family informants bereaved by suicide



CONCERNS REPORTED BY BEREAVED FAMILY MEMBERS

During the interview stage of the study, family members demonstrated commendable bravery when discussing events surrounding the loss of their loved one and their own interpretation of such a painful experience. Thirteen family members (54%) expressed concern over the treatment their deceased family member received while on ward, and believed they would also have been helped if they had received more support during their loved ones' illness. The remaining 11 family members reported positive interactions with staff, including being given reassurance and being urged to recognise and take care of their physical health during stressful times. It was also noted that nursing staff commonly stayed beyond the end of their shift to continue conversations with family members and service users.

Those who retrospectively reported a negative experience described how they felt intimidated and excluded by ward protocol. Some ward activities were considered unchallenging and highly unsuitable, at times causing embarrassment to the service user. The use of 'technical language' beyond their comprehension caused confusion, as did reports of communication difficulties when English wasn't the first language of hospital staff.

There were issues surrounding risk assessment, particularly in cases where documented risk wasn't disclosed to next of kin, despite being clearly stated. Lack of consultation regarding leave decisions contributed to anxiety, for example when being asked to sign documentation stating the patient would be in their charge while off the psychiatric ward (n=<5). Feeling uninformed about mental health legislation, mental health policy and procedure and even unsatisfactory meetings with medical staff have left families with feelings of anger or frustration. Their experience of the care pathway for their relative highlighted episodes of ineffective or miscommunication and feelings that valuable information families felt they could contribute was not taken into consideration (n=11).

The issue of patient confidentiality and subsequent clinical disclosure was at the core of most concerns reported by 13 family members, particularly when service users clearly expressed suicidal feelings which were withheld from their care-giver at time of discharge. Caregivers were not always confident that their concerns for their loved one were adequately addressed. Copies of letters sent to services following patient death which described substantial perceived failures in treatment and service were given to the researcher by three separate family members. They reported retrospective feelings of hostility towards the medical team who had failed to inform them of documented suicide risk or planning of suicidal behaviour. As a consequence, this was a cause of considerable distress during the grieving process for family members.

In 12 cases, notes in clinical records state that contact was made by a member of the mental health services offering condolences and support. Conversely, these accounts are not supported by the majority of caregivers who recall no such interaction and expressed considerable anger at a perceived lack of communication from services. In some cases, clumsy and insensitive approaches by services towards bereaved family members compounded the grief and uncertainty they felt. It must be noted, however, that recall may become skewed in the aftermath of extreme and traumatic life events.

5. Review of suicide and self-harm reports by the media in the Donegal area

In order to verify the extent of media reporting of cases of suicide or probable suicide included in the sample, a search of regional media outlets in County Donegal and nationally was conducted by the National Media Monitoring Agency covering the period January 2011 until March 2015.

The search of media articles referring to suicide and probable suicide revealed 1581 newspaper articles. Each article was screened according to the guidelines for media reporting (Samaritans, 2010). 30 were articles identified reporting on suicide in County Donegal. Fourteen guidelines were considered in the screening of articles from media outlets in Donegal relating to specific cases of suicide. Table 7 details the results of the screening task.

Table 7: Suicide Case Reporting in the Donegal Media

	MEDIA GUIDELINES - VIOLATIONS	% TOTAL	(N)
1.	Sensationalised language – inappropriate language used to describe the mental health of a person or the event, e.g. 'maniac', 'epidemic'	13.3%	4
2.	Reported on front page – article relating to suicide case is published on the front page of newspaper	16.6%	5
3.	Committed and or suicide in headline – the words 'committed suicide' were included in the headline of the article	13.3%	4
4.	Photographs included – photographs of the scene or other inappropriate photos published (e.g. coffin, cemetery, mourning scene including identifiable attendees)	33.3%	11
5.	Location – location of the suicide mentioned or pictured, particularly landmarks	16.6%	5
6.	Method – details or description of the method of the suicide mentioned (e.g. hanged, overdose)	16.6%	5
7.	Suicide note – information regarding a suicide note disclosed. In light of advancing technology this is extended to include communication via social media, text message etc.	30%	9
8.	Time of transition – high risk time of year, refers to holiday times such as Christmas, Valentine's Day etc, or any period associated with increased familial stress.	33.3%	10
9.	Reference to wider issues – e.g. alcohol or other substance misuse, mental health status, service use history	13.3%	4
10.	Support information – article included supportive information such as support websites and helpline numbers to facilitate direct contact	26.6%	8
11.	Interviewing bereaved – family or friends of deceased interviewed, quotes may be included	26.6%	8
12.	Reference to incident that may have caused suicide – suggestions on what may have caused/attributed to the fatal event (e.g. breakdown of marriage, financial debt)	63.3%	20
13.	Community grief over emphasised – reports of a community in mourning over the death	56.6%	15
14.	Accurate statistics – credible statistics from a legitimate source reported in the article.	3.3%	1

MEDIA REPORTING OF SUICIDE

Overall, journalistic reporting was mindful of the effect over-sensationalised reports can have on family and friends of the deceased, as well as the community. However, comments such as "society has failed us" and "we are failing the most fragile" suggested systemic failure among health and government agencies. A quote from a parish priest, 'for the love of god, let some one person in government take leadership and reform what is clearly a broken system' appealed for change to the current system. In a series of articles reporting the suicide of two family members within a short period of time, sensationalised language was used to describe the 'desperately shocking tragedy'. Terms such as 'pain' and 'shattered' were used to express community grief, particularly those depicting the scene of a funeral. Iconicizing death in this way can have a significant impact on vulnerable individuals (Tor, Ng & Ang, 2008). Emotive language was used in headlines of the articles reviewed, with almost a fifth (16.6%) of the articles displayed on the front page, although none of those used the word 'suicide.' 10% displayed an image of the deceased or bereaved on the front page. A murder suicide was described 'criminal' and 'grotesque,' alluding to the notion that mental health issues are problems beyond individual control. References to the bereaved included 'the desperate pain and deep anguish of losing a loved one in the most tragic of circumstances.' Links between suicide and social media were emphasized, particularly with reference to online bullying. Suicide amongst young people and the association between social media and cyber bullying was consistently mentioned in younger deaths. Accurate statistics on rates of suicide were presented in only one article.

Approximately a fifth of articles (16.6%) reporting a case of suicide made reference to the scene, including the geographical location. The WHO (2008) caution against providing detail of suicide sites to prevent a 'contagion effect' and labelling locations as suicide 'hot-spots' thus drawing more vulnerable individuals to that particular place. 16.6% of articles revealed the suicide method. Journalists are urged to exercise caution when referring to the method used by the individual to avoid imitation known as 'copy-cat' suicide (Pirkis & Blood, 2001). As recommended by media guidelines, all reports refrained from including details of the suicide method in the headlines of their articles. 30% of articles made reference to a suicide note despite assertions by the Samaritans that such disclosure may sensationalise the event and cause further distress to the bereaved (Samaritans, 2010). 26.6% of articles provided support information such as helpline numbers and website information in conclusion. Sustained collaboration between media personnel and mental health care providers, combined with increased journalistic awareness may encourage a more appropriate means of reporting suicide.

6. Conclusion

This report offers a unique opportunity to obtain greater insight into suicide among people who were in the care of the Donegal Mental Health Services covering the period October 2011-May 2015. The independent nature of the research, which was fully supported and facilitated by a multidisciplinary Steering Group, adds to the validity of the research findings, and evidence based recommendations and associated actions. The findings are further strengthened by the high response rates and completeness of the information obtained from multiple sources including clinical records, psychological autopsy interviews with family informants, Coroners' records, post-mortem reports, and questionnaires from health care professionals, which represents the fundamental SSIS-PAM approach. Therefore, the report represents a valuable resource to make a difference in terms of increasing awareness, improving assessment and management of people at risk of suicidal behaviour in a mental health service setting. Service improvement for people at risk of suicide and supporting families in the aftermath of death by suicide of a family member are on-going key priorities of national and international guidelines and recommendations furthering suicide prevention (Department of Health, 2015; World Health Organization, 2014).

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Appendix 1

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Address line 1
Line 2
Line 3
Line 4

Date:

Dear NAME OF FAMILY INFORMANT

Following our recent telephone conversation, I am writing requesting your participation in a review being instigated by Donegal Mental Health Service following up with families who have been bereaved in the past two and a half years following the untimely sudden death of a loved one who had previously, or was at the time of death, attending the service.

The aim of this review is two-fold. Firstly, we would like to discuss the supports offered to you at the time of your loved one's death and any on-going support needs arising from your loss. In order to continue to improve the treatment and prevention programmes for people requiring treatment, especially those most at risk, we need to understand the factors which may contribute to untimely sudden deaths. This is the second aim of this review and we would like to include your views as a family member. Participation in this review is completely voluntary.

We are working with Professor Ella Arensman, a recognised authority in this area, who will lead this review. In agreeing to take part, you are giving permission to provide your contact details to Prof Arensman. A member of her team, Dr Colette Corry, would then write to you to arrange a meeting.

If you do not wish to be contacted further in relation to this please complete the refusal slip and return to St Conal's Hospital, Letterkenny. Alternatively, you can email or telephone Dr Corry (details below). Thank you for taking the time to consider participating in this review.

Yours sincerely,

Dr Clifford Haley
Clinical Director
Donegal Mental Health Service

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Refusal slip

I have received and read a letter of invitation for participation in the proposed review.
I do not wish to participate or to be contacted further in relation to this review.

Signature: _____

Name in block capitals: _____

Date: _____

Contact Details:

E-mail: Colette.corry@ucc.ie

Appendix 2

National Suicide Research Foundation

University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Name of GP
Address line 1
Address line 2
Address line 3

Date:

Dear Dr _____

Re: Research into untimely sudden deaths including suicide in Donegal

We are contacting you to ask if you would be interested in participating in a research project involving the views of the next of kin of those who died suddenly while under the care of Donegal Mental Health Services. This project operates in close collaboration with the Irish Coroner's system. The main objectives of the study are to:

- Improve provision of support to the bereaved (untimely sudden deaths including suicide).
- Identify and better understand the causes of sudden deaths and suicide.
- Better define the incidence and pattern of sudden deaths and suicide in Ireland.
- Identify and improve the response to clusters of suicide.

This project is being carried out by a research team of the National Suicide Research Foundation at University College Cork under the supervision of Professor Ella Arensman, and is funded by the National Office for Suicide Prevention. The research project and the approach outlined here have been approved by the Research Ethics Committee at Letterkenny General Hospital.

The approach taken in the current research project follows from the four-year pilot Suicide Support and Information System in Cork and is similar to previous studies in other countries, for example the National Confidential Inquiry into Suicide and Homicide in the UK, which includes involvement of family members or friends of people who died by suicide or probable suicide. In addition, with the consent of a next-of-kin, contact is being sought with a health care professional, such as a General Practitioner or Psychiatrist who had been in contact with the deceased in the year prior to death. It is anticipated that this will result in a greater depth and range of information concerning the deceased being collected.

For the reasons outlined above, and with the permission of FAMILY INFORMANT we are contacting you in relation to the death of your patient NAME AND DATE OF BIRTH which occurred in tragic circumstances on DATE OF DEATH.

The enclosed questionnaire covers relevant themes in relation to the death, such as the situation around the time of death, physical and mental health, family and personal history, life events, and social support.

Completion of this questionnaire is completely voluntary and the information provided will be treated as fully confidential and only used for the purpose of this research project.

Yours sincerely,

Dr Colette Corry
Senior Research Psychologist
National Suicide Research Foundation
University College Cork
E-mail: Colette.corry@ucc.ie
Mob Tel: 0873430021
St. Conal's Ext: 3762

Yours sincerely,

Professor Ella Arensman
Research Director
National Suicide Research Foundation
University College Cork

Appendix 3

Glossary of terms

AMA	Against Medical Advice
AU	Addiction Unit
CASIG	Client's Assessment of Strengths, Interests and Goals
COSC	National Office for the Prevention of Domestic, Sexual and Gender-based Violence
CREATE	National development agency for collaborative arts in social and community contexts
CSA	Central Services Agency
DNA	Did Not Attend
GP	General Practitioner (own doctor)
INP	In-Patient status
NS	Nursing Staff
OP	Out-Patient status
OPD	Out-Patient Department
OT	Occupational Therapist
STEER	Support Training Education Employment and Research

Treatment trajectory: a comprehensive case summary which details referrals, admissions, agency involvement, discharge and appointments the deceased failed to attend. This allows examination of service provision and uptake of individual cases and identifies episodes of dis-engagement both by the service user and services.

Appendix 4

ID number ☐☐☐

A Research Study into a Potential Suicide Cluster in Donegal

Questionnaire for Health Care Professional

Suicide Support and Information System in Ireland

National Suicide Research Foundation

July 2015

Dr Colette Corry
Professor Ella Arensman

NSRF, Dept of Epidemiology & Public Health, University College Cork.
4.28 Western Gateway Building
Western Road
Cork
T: 021 4205547

Please return completed questionnaire to:
Dr Colette Corry
Room 0087
St. Conal's
Letterkenny General Hospital

The study is funded by the National Office for Suicide Prevention
A number of items in this questionnaire have been adapted from the Suicide Questionnaire Version: 04/2005 of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, Centre for Suicide Prevention, Jean McFarlane Building, University of Manchester.

ID number ☐☐☐

DEMOGRAPHIC INFORMATION

1. Date of birth ☐☐-☐☐-☐☐☐☐

2. Marital status

☐ 1. Single
☐ 2. Married/co-habiting
☐ 3. Widowed
☐ 4. Divorced (if yes, how many times) _____
☐ 5. Separated
☐ 99. Not known

3. Sexual Orientation (if known)

☐ 1. Heterosexual
☐ 2. Homosexual
☐ 3. Bi-sexual
☐ 4. Trans-sexual
☐ 99. Not known

4. Accommodation (for inpatients give accommodation prior to admission)

☐ 1. Homeless/no fixed abode
☐ 2. Supervised hostel
☐ 3. Unsupervised hostel
☐ 4. Rented house or flat
☐ 4. Other house or flat
☐ 5. Prison
☐ 99. Not known
☐ 6. Other (please specify) _____

5. Living arrangements

☐ 1. Alone
☐ 2. With family of origin
☐ 3. With partner/spouse only
☐ 4. With partner/spouse and children
☐ 5. With child(ren) only
☐ 6. Other shared (e.g. friends)
☐ 8. Other (please specify)
☐ 99. Not known

6. Number of children (please specify ages) _____

☐ 99. Not known

7. Was the deceased providing care for any children under the age of five years?

☐ 1. No
☐ 2. Yes: full-time/live-in care
☐ 3. Yes: part-time care
☐ 99. Not known

8. Employment status

☐ 1. Paid employment (including part-time)
☐ 2. Unemployed
☐ 3. Self-employed
☐ 4. Housewife/husband
☐ 5. Full-time student
☐ 6. Long term disability
☐ 7. Retired
☐ 8. Sick leave
☐ 9. Unpaid occupation
☐ 10. Other (please specify)
☐ 99. Not known

9. Profession (please specify) _____

☐ 99. Not known

11. Place of work or school (please specify) _____

☐ 99. Not known

12. Medical card

☐ 1. No ☐ 2. Yes ☐ 99. Not known

CAUSE(S) OF DEATH

Prior to sending you this form, we have usually been informed that the death has been classified as suicide or undetermined (open verdict, possible suicide).

Cause of death from medical evidence

_____

_____

_____

PRECIPITANTS TO DEATH

As far as you are aware of the situation of the deceased in the year prior to his/her death, had the deceased recently experienced or was he/she anticipating any significant event or experience?

Examples can include a significant loss (job loss, financial loss), relationship problem, legal trouble, traumatic event, major life change (positive and negative), anniversary, suicide or suicidal behaviour among significant others or other events

Please complete in the space provided below. If not known please enter 99

_____

_____

_____

HISTORY OF NON-FATAL SUICIDAL BEHAVIOUR

1. (a) Prior to his/her death, did the deceased ever before deliberately harm him/herself?

For example, by taking an overdose of medication or drugs, by attempting to hang or drown him/herself

☐ 1. Yes ☐ 2. No ☐ 99. Not known

1. (b) If yes, how many times? _____

2. Please indicate below what you know of the last previous episode of deliberate self-harm

A. Method

☐ 1. Intentional overdose ☐ 1a. Prescribed ☐ 1b. Over the counter
☐ 1c. Illicitly obtained ☐ 1d. Other

☐ 2. Hanging ☐ 3. Drowning
☐ 4. Cutting ☐ 5. Jumping from height
☐ 6. Burning ☐ 7. Other poisoning
☐ 8. Other ☐ 99. Not known
☐ Not applicable

B. Time lapse between episode of deliberate self-harm and death (approximate if necessary)

_____ Years _____ Months _____ Days

C. Medical treatment following self harm

☐ 1. None ☐ 2. General Practitioner ☐ 3. A&E
☐ 4. Other ☐ 99. Not known ☐ Not applicable

Enter what you consider to be the most accurate answer in the space provided.
If not known, please enter or tick 99 as appropriate. Please answer ALL questions.

D. Psychiatric treatment following self harm

☐ 1. None ☐ 2. In-patient ☐ 3. Out-patient ☐ 99. Not known

FAMILY AND PERSONAL HISTORY

1. Was the deceased ever a victim of significant physical, sexual or emotional abuse?

☐ 1. No ☐ 2. Yes (please give details below) ☐ 99. Not known

---

2. Was a family member of the deceased ever a victim of significant physical, sexual or emotional abuse?

☐ 1. No ☐ 2. Yes (please give details below) ☐ 99. Not known

---

3. Was the deceased ever a perpetrator of significant physical, sexual or emotional abuse?

☐ 1. No ☐ 2. Yes (please give details below) ☐ 99. Not known

---

4. Was a family member of the deceased ever a perpetrator of significant physical, sexual or emotional abuse?

☐ 1. No ☐ 2. Yes (please give details below) ☐ 99. Not known

---

5. Was the deceased ever a victim of violent behaviour?

☐ 1. No ☐ 2. Yes (please give details below) ☐ 99. Not known

---

6. Was a family member of the deceased ever a victim of violent behaviour?

☐ 1. No ☐ 2. Yes (please give details below) ☐ 99. Not known

---

7. Was the deceased ever a perpetrator of violent behaviour?

☐ 1. No ☐ 2. Yes (please give details below) ☐ 99. Not known

---

8. Was a family member of the deceased ever a perpetrator of violent behaviour?

☐ 1. No ☐ 2. Yes (please give details below) ☐ 99. Not known

---

9. Had either of the deceased's parents resided in an orphanage, industrial school, or in foster care?

☐ 1. No ☐ 2. Yes (please give details below) ☐ 99. Not known

---

10. Difficulties with the Gardai (please give details)

☐ 1. No ☐ 2. Yes (please give details below) ☐ 99. Not known

PSYCHIATRIC HISTORY

In relation to any psychiatric illnesses with which the deceased was diagnosed:

1. If the deceased was diagnosed with a psychiatric illness, who made this diagnosis?

(Doctor's name)

2. Date of psychiatric diagnosis: ☐☐-☐☐☐☐
Month Year

3. Psychiatric diagnosis (please indicate whether it was in accordance with ICD-10 or DSM IV, depending on which diagnostic classification was used by yourself or another health care professional):

☐ ICD-10 ☐ DSM IV ☐ Not known ☐ Not applicable

Primary Diagnosis

☐ 01 Schizophrenia and/or other psychotic disorders
☐ 02 Bipolar affective disorder
☐ 03 Depressive illness
☐ 04 Anxiety/phobia/panic disorder/OCD
☐ 05 Eating disorder
☐ 06 Dementia
☐ 07 Alcohol dependence
☐ 08 Drug dependence
☐ 09 Personality disorder
☐ 10 Adjustment disorder/reaction
☐ 11 Organic disorder
☐ 12 Alcohol misuse, but not dependence
☐ 13 Drug misuse
☐ 77 No mental disorder
☐ 88 Other (please specify)
☐ 99 Not known

Secondary Diagnosis (Coding as above)

1. _____ 2. _____ 3. _____ 4. _____

Duration (since clear onset of disorder coded under primary diagnosis above)

_____Year(s) _____Month(s) ☐ NA ☐ Not known

RECENT SYMPTOMS/BEHAVIOURS

Please read through the following list of depressive symptoms and tick any of those which were relevant to the situation of the deceased in the **week** prior to his/her death.

Symptoms of Depression

How much did they experience:	Not at all	Moderately	Quite a bit	Extremely
Feeling blue				
Blaming him/herself for things				
Worrying too much about things				
Feeling everything was an effort				
Feeling low in energy/slowed down				
Feeling no interest in things				

Symptoms of Mania

Did the deceased exhibit:	Yes	No	Not known
Excessively "high" mood			
Irritability			
Decreased need for sleep			
Increased energy			
Increased talking, moving, and sexual activity			
Racing thoughts			
Disturbed ability to make decisions			
Grandiose notions			
Being easily distracted			

PHYSICAL HEALTH

This section examines the deceased's physical well-being.

1. Had the deceased been diagnosed with any significant physical illness or disease? (Include conditions even if well controlled by treatment)

☐ 1. No ☐ 2. Yes (please specify which physical illness(es) ☐ 99. Not known

2. Was the deceased in physical pain in the year prior to death?

☐ 1. No ☐ 2. Yes (Please give details, e.g. duration) ☐ 99. Not known

3. Was this physical illness chronic? (I.e. duration over 12 months)

☐ 1. No ☐ 2. Yes ☐ 3. Not applicable ☐ 99. Not known

4. Did the deceased experience a reduction in his/her physical capabilities prior to his/her death?

☐ 1. No ☐ 2. Yes (please give details e.g. duration) ☐ 99. Not known

5. Was the deceased on prescribed medication for a physical illness?

☐ 1. No ☐ 2. Yes ☐ 99. Not known

If yes: To the best of your knowledge, did he/she adhere to the instructions on the medication?

☐ 1. No ☐ 2. Yes ☐ 99. Not known

6. (Female) Was the deceased

☐ 1. Premenopausal ☐ 2. Peri-menopausal ☐ 3. Postmenopausal

7. (Male) Any other physical condition (eg. Hormonal)

☐ 1. No ☐ 2. Yes ☐ 99. Not known

8. (Male) If yes to item 7, please give details

SUBSTANCE ABUSE

This section explores the deceased's use, if relevant, of alcohol and drugs and asks about any recent changes in this behaviour in the year prior to death.

ALCOHOL

1. Did the deceased have a history of alcohol abuse?

☐ 1. No ☐ 2. Yes (please give details e.g. timing) ☐ 99. Not known

---

2. Had the deceased made any recent attempts (in the year prior to death) to stop abusing alcohol?

☐ 1. No ☐ 2. Yes (please give details e.g. timing) ☐ 99. Not known

---

3. Was there a recent increase in the deceased's abuse of illicit drugs?

☐ 1. No ☐ 2. Yes (please give details e.g. timing) ☐ 99. Not known

---

4. Was there any evidence that the deceased had been drinking at the time of death?

☐ 1. No ☐ 2. Yes (please give details e.g. timing) ☐ 99. Not known

---

ILLICIT DRUG USE

1. Did the deceased have a history of illicit drug abuse?

☐ 1. No ☐ 2. Yes (please give details e.g. duration) ☐ 99. Not known

---

2. Had the deceased made any recent attempts, to stop abusing illicit drugs?

☐ 1. No ☐ 2. Yes (please give details e.g. timing) ☐ 99. Not known

---

3. Was there a recent increase in the deceased's abuse of illicit drugs?

☐ 1. No ☐ 2. Yes (please give details e.g. duration) ☐ 99. Not known

---

4. Was there any evidence that the deceased had been taking illicit drugs at the time of death?

☐ 1. No ☐ 2. Yes (please give details) ☐ 99. Not known

TREATMENT HISTORY

1.How many times did the deceased attend your practice during the last year?

☐ 1. Never in the past year ☐ 2. Once
☐ 3. Twice ☐ 4. Three times
☐ 5. Four or more times.

2. Please indicate in the spaces provided below when the deceased last attended your practice? What was his/her reason? Did you prescribe any medicines?

Date of last contact: ☐☐-☐☐-☐☐☐☐
Day Month Year

☐ 1. Physical ☐ 2. Psychological ☐ 3. Both
Medicines prescribed: ☐ 1. Yes ☐ 2. No

If medicines were prescribed, did the deceased use any of the medicines prescribed in that contact for self-poisoning/overdose?

☐ 1. Yes ☐ 2. No ☐ 99. Not known

3. At the time of the deceased's last contact with you, did he/she mention any thoughts of harming him/herself?

☐ 1. Yes (please specify)

_____

☐ 2. Vaguely referred to (please specify)

_____

☐ 3. No

4. Was the deceased treated as an inpatient at a psychiatric hospital or on the psychiatric ward of a general hospital in the year prior to death?

☐ 1. Never ☐ 2. Once
☐ 3. Twice ☐ 4. Three times
☐ 5. Four times or more

PSYCHIATRIC TREATMENT

1. Psychiatric admissions (if one or more times in inpatient treatment):
Number of admissions to psychiatric in-patient ward (including ATOD)

☐ None ☐ 1-5 admissions ☐ More than 5 admissions

2. Out-patient psychiatric treatment and day care.
Was the deceased ever in contact with any of the following professional services for treatment or advice, to the best of your knowledge?

Psychiatric service - public	Yes	No
1. Private psychologist/psychiatrist		
2. Community mental health nurse		
3. Alcohol/Drug Addiction services		
4. Consultation for relationship/sexual problems		

3. Other treatment of emotional problems.
Did the deceased ever receive treatment or assistance for emotional problems from anyone else as far as you know? For example, Alcoholics Anonymous, helplines, etc.

☐ 1. No ☐ 2. Yes (please specify)

---

4. Date of last point of psychiatric treatment

Inpatient _____

Outpatient _____

PSYCHOTROPIC MEDICATION

For each of the following drugs please specify whether, to your knowledge, the drugs were prescribed and whether the patient was compliant (i.e. taking drug(s) as prescribed)

1. Not prescribed
2. Prescribed and thought to be compliant
3. Prescribed and thought not to be compliant

☐ 1. Oral typical anti-psychotic drugs (e.g. chlorpromazine, haloperidol)
☐ 2. Oral atypical anti-psychotic drugs (e.g. clozapine, risperidone)
☐ 3. Depot typical anti-psychotic drugs (e.g. flupenthixol, zuclopenthixol)
☐ 4. Depot atypical anti-psychotic drugs (e.g. risperidone)
☐ 5. Lithium/mood stabilisers
☐ 6. Tricyclic anti-depressants
☐ 7. SSRI anti-depressants
☐ 8. SNRI anti-depressants
☐ 9. Other anti-depressants
☐ 10. Methadone
☐ 11. Other psychotropic drug (please specify)

Did the patient complain of distressing psychotropic drug side-effects?

☐ 1. No ☐ 2. Yes

If yes, please describe

COMPLIANCE

Was the patient known to be compliant with prescribed medication?

☐ 1. Yes ☐ 2. No

Reason for non-compliance with treatment

☐ 1. Side effects
☐ 2. Lack of insight into illness
☐ 3. Side effects and lack of insight
☐ 4. Due to distance from pharmacy
☐ 5. Dependence (e.g. persistent benzodiazepine use against medical advice)
☐ 6. Due to distance from services
☐ 7. Not applicable as patient was compliant with drug treatment
☐ 8. Not applicable as patient did not receive drug treatment
☐ 9. Other (please specify)

_____

ADDITIONAL INFORMATION

Please use this section to provide any additional information you deem pertinent to this enquiry.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for completing this questionnaire.
We sincerely appreciate your time and input in this important study.

Appendix 5

ID number ☐☐☐

A Review of Sudden Untimely Deaths involving Users of Donegal Mental Health Services

Interview Instrument for Informant Family member or friend

National Suicide Research Foundation

June 2014

Dr Colette Corry
Professor Ella Arensman
Room 4.28 Western Gateway Building
Western Road
Cork

T: 0873430021
E-mail: Colette.corry@ucc.ie

GENERAL INTERVIEW INFORMATION

Place of interview _____

Date of interview ☐☐-☐☐-☐☐☐☐ (Day Month Year) Time of interview ☐☐-☐☐ (Hour Min)

FIRST SESSION

Date started: ☐☐-☐☐-☐☐☐☐ (Day Month Year) Time started and ended ☐☐-☐☐ (Hour Min) ☐☐-☐☐ (Hour Min)

If interview completed in two sessions

SECOND SESSION

Date started: ☐☐-☐☐-☐☐☐☐ (Day Month Year) Time started and ended ☐☐-☐☐ (Hour Min) ☐☐-☐☐ (Hour Min)

Special observations or remarks: reason for refusal or interview not taking place or interview partially completed

_____

☐ 1. Completed
☐ 2. Partially completed
☐ 3. Not completed

TO BE FILLED IN WHEN THE INTERVIEW IS COMPLETED

STANDARD SOCIO-DEMOGRAPHIC INFORMATION

Now that you know what this interview is for and have signed the consent form, let us start with some general questions about yourself and then similar questions about the deceased (name) (age, gender, occupation etc). If on any question you either cannot or don't want to give an answer, please say so. I would like to emphasise again that participating in this interview is completely voluntary. Now before we start, do YOU have any questions?

INTERVIEWEE

1. Gender ☐ 1. Male ☐ 2. Female

2. Age: _____

3. Relationship to the deceased: _____

DECEASED

1. Date of birth ☐☐-☐☐-☐☐☐☐

1. Gender ☐ 1. Male ☐ 2. Female

3. Nationality (please specify) _____

4. Ethnic Origin _____

5. Religion _____

6. Marital status

☐ 1. Single
☐ 2. Married/co-habiting
☐ 3. Long-term relationship
☐ 4. Widowed
☐ 5. Divorced - if yes, how many times: _____
☐ 6. Separated
☐ 99. Not known

7. Accommodation (for inpatients give accommodation prior to admission)

☐ 1. Homeless/no fixed abode
☐ 2. Supervised hostel
☐ 3. Unsupervised hostel
☐ 4. Rented house or flat
☐ 5. Other house/flat
☐ 6. Prison
☐ 7. Other (please specify) _____
☐ 99. Not known

8. Living arrangements

☐ 1. Alone
☐ 2. With family of origin
☐ 3. With partner/spouse only
☐ 4. With partner/spouse and children
☐ 5. With child(ren) only
☐ 6. Other shared (e.g.friends)
☐ 7. Other (please specify) _____
☐ 99. Not known

9. Number of children (please specify)

_____
☐ 99. Not known

10. Was the deceased providing care for any children under the age of five years?

☐ 1. No ☐ 2. Yes: full-time/live-in ☐ 2. Yes: part-time ☐ 99. Not known

11a. Employment status

☐ 1. In paid employment (including part-time)
☐ 2. Unemployed
☐ 3. Self-employed
☐ 4. Housewife/husband
☐ 5. Full-time student
☐ 6. Long term disability
☐ 7. Retired
☐ 8. Sick leave
☐ 9. Unpaid occupation
☐ 10. Other (please specify) _____

11b. Nature of employment contract

☐ 1. Permanent
☐ 2. Temporary (e.g. agency work)
☐ 3. Fixed-term
☐ 4. Occasional
☐ 5. Sporadic-hourly
☐ 99. Not known

11c. Sector of employment

☐ **A** – AGRICULTURE, FORESTRY AND FISHING
☐ **B** – MINING AND QUARRYING
☐ **C** – MANUFACTURING
☐ **D** – ELECTRICITY, GAS, STEAM AND AIR CONDITIONING SUPPLY
☐ **E** – WATER SUPPLY;SEWERAGE,WASTE MANAGEMENT AND REMEDIATION ACTIVITIES
☐ **F** – CONSTRUCTION
☐ **G** – WHOLESALE AND RETAIL TRADE; REPAIR OF MOTOR VEHICLES AND MOTORCYCLES
☐ **H** – TRANSPORTATION AND STORAGE
☐ **I** – ACCOMMODATION AND FOOD SERVICE ACTIVITIES
☐ **J** – INFORMATION AND COMMUNICATION
☐ **K** – FINANCIAL AND INSURANCE ACTIVITIES
☐ **L** – REAL ESTATE ACTIVITIES
☐ **M** – PROFESSIONAL, SCIENTIFIC AND TECHNICAL ACTIVITIES
☐ **N** – ADMINISTRATIVE AND SUPPORT SERVICE ACTIVITIES
☐ **O** – PUBLIC ADMINISTRATION AND DEFENCE;COMPULSORY SOCIAL SECURITY
☐ **P** – EDUCATION
☐ **Q** – HUMAN HEALTH AND SOCIAL WORK ACTIVITIES
☐ **R** – ARTS, ENTERTAINMENT AND RECREATION
☐ **S** – OTHER SERVICE ACTIVITIES
☐ **T** – ACTIVITIES OF HOUSEHOLDS AS EMPLOYERS;UNDIFFERENTIATED GOODS- AND SERVICES-PRODUCING ACTIVITIES OF HOUSEHOLDS FOR OWN USE
☐ **U** – ACTIVITIES OF EXTRA TERRITORIAL ORGANISATIONS AND BODIES

11d. Skill discretion

☐ 1. With supervisory function ☐ 2. Without supervisory function

12. Profession (please specify; include last profession if retired or unemployed)

_____ ☐ 99. Not known

13. Place of work or school (if appropriate)

_____ ☐ 99. Not known

14. Medical card

☐ 1. No ☐ 2. Yes ☐ 99. Not known

15. Highest level of education obtained

☐ 1. Entered Primary level

2. ☐ Entered Secondary level
☐ Completed Junior/Inter Cert
☐ Completed Senior/Leaving Cert

☐ 3. Entered Third level ☐ 4. Entered Fourth level

☐ 5. Other course e.g. PLC, apprenticeship ☐ 99. Not known

16. History of residence in an industrial school, orphanage or foster care as a child?

☐ 1. No ☐ 2. Yes ☐ 99. Not known (please specify) _____

17. History of being in prison at any time before death (includes being a remand prisoner)

☐ 1. No ☐ 2. Yes ☐ 99. Not known

SITUATION AT TIME OF DEATH

Can you tell me in your own words what you know about how the deceased (name) died? Do you know what caused his/her death?

(Interviewer completes this section based on the interviewee's response)

1. Cause(s) of death (if more than one please give direct cause)

☐ 01. Overdose
☐ 02. Carbon monoxide poisoning
☐ 03. Hanging
☐ 04. Drowning
☐ 05. Firearms
☐ 06. Cutting or stabbing
☐ 07. Jumping from a height
☐ 08. Jumping/lying before a train
☐ 09. Jumping/lying before a road vehicle
☐ 10. Suffocation
☐ 11. Burning
☐ 12. Electrocution
☐ 13. Jumping/lying before an unspecified object
☐ 14. Strangulation
☐ 15. Other self-poisoning
☐ 88. Other (please specify)
☐ 99. Not known

_____

2. If overdose or self-poisoning, specify substance. Can you recall the prescription name(s) of the drug(s)?

_____

(If interviewee is unsure of the prescription name ask them to select from the following categories)

☐ 00. Method not self-poisoning
☐ 01. Anti-psychotic drug
☐ 02. Tricyclic anti-depressant
☐ 03. SSRI/SNRI anti-depressant
☐ 04. Lithium/Mood stabiliser
☐ 05. Other anti-depressant
☐ 06. Benzodiazepine/Hypnotic
☐ 07. Paracetamol
☐ 08. Paracetamol/Opiate compound
☐ 09. Salicylate
☐ 10. Other analgesic
☐ 11. Opiate (heroin, methadone)
☐ 12. Insulin
☐ 13. Other poisons (eg weedkiller, gases); please specify _____
☐ 14. Unspecified psychotropic drug
☐ 88. Other drug (please specify) _____
☐ 99. Not known

3. If overdose, where did the substance come from?

☐ 1. Prescribed for the deceased ☐ 2. Prescribed for someone else
☐ 3. Not prescribed (e.g. black market, peers, workplace)
☐ 99. Not known ☐ 77. Not applicable (Method not self-poisoning)

4. Was alcohol consumed as part of the act?

☐ 1. No ☐ 2. Yes ☐ 99. Not known

FOR CASES OF SUICIDE OR POSSIBLE SUICIDE:

5. Was the death part of a pact?

☐ 1. No ☐ 2. Yes ☐ 99. Not known

6. Are you aware of any suicide notes or other messages including text messages left by the deceased?

☐ 1. No ☐ 2. Yes (If yes, please give details e.g. wording, timing)

---

7. Circumstances around the act

Can you tell me in your own words what you know about the actions of the deceased (name) in the hours before they died?

(Interviewer completes this section based on the interviewee's response)

A. Isolation

☐ 0. Somebody present ☐ 1. Somebody nearby, or in visual or vocal contact
☐ 2. No one nearby or in visual or vocal contact ☐ 99. Not known

B. Timing

☐ 0. Intervention is probable ☐ 1. Intervention is not likely
☐ 2. Intervention is highly unlikely ☐ 99. Not known
Please specify:

C. Precautions against discovery/intervention

☐ 0. No precautions ☐ 1. Passive precautions (as avoiding other but doing nothing to prevent their intervention; alone in room with unlocked door)
☐ 2. Active precautions (as locked door) ☐ 99. Not known
Please specify:

D. Acting to get help during/after attempt

☐ 0. Notified potential helper regarding attempt ☐ 1. Contacted but did not specifically notify potential helper regarding attempt
☐ 2. Did not contact or notify potential helper ☐ 99. Not known
Please specify:

E. Final acts in anticipation of death (will, gifts, insurance)

☐ 0. None ☐ 1. Thought about or made some arrangements
☐ 2. Made definite plans or completed arrangements ☐ 99. Not known
Please specify:

F. Active preparation for attempt

☐ 0. None ☐ 1. Minimal to moderate ☐ 2. Extensive ☐ 99. Not known
Please specify:

G. Suicide Note

☐ 0. Absence of note ☐ 1. Note written, but torn up; note thought about
☐ 2. Presence of note ☐ 99. Not known
Please specify:

H. Overt communication of intent before the attempt

☐ 0. None ☐ 1. Equivocal communication
☐ 2. Unequivocal communication ☐ 99. Not known
Please specify:

FOR CASES OF SUICIDE OR POSSIBLE SUICIDE:

EVENTS LEADING TO DEATH

I would like to ask you some questions now regarding the situation of the deceased (name) in the time prior to his/her death. I will start by listing some possible life events and you can tell me if any of these were relevant to the deceased (name).

1. In the time prior to his/her death, had the deceased (name) experienced or was the deceased anticipating:

(a) Becoming unemployed?

☐ No ☐ Perceived possibility of becoming unemployed ☐ Dismissed from job
☐ Made redundant ☐ Became retired ☐ Not applicable ☐ Not known

_____ weeks _____ days _____ hours before death

If yes, please specify: _____

(b) Significant (or perceived significant) disruption of a romantic relationship?

☐ No ☐ Separation ☐ Divorce ☐ Break-up
☐ Argument ☐ Not applicable ☐ Not known

_____ weeks _____ days _____ hours before death

If yes, please specify: _____

(c) Legal troubles or difficulties with the Gardai?

☐ No ☐ Arrest ☐ Known to Gardai ☐ Pending court case
☐ Imprisoned at time of death ☐ Released from prison ☐ Other ☐ Not known

_____ weeks _____ days _____ hours before death

If yes, please specify: _____

(d) Significant interpersonal conflict

☐ No ☐ Not specified ☐ Familial conflict ☐ Friend conflict
☐ Work conflict ☐ Other conflict ☐ Not known

_____ weeks _____ days _____ hours before death

If yes, please specify: _____

(e) An event which was or was perceived as traumatic?

☐ No ☐ Victim of violent or sexual assault
☐ Involved in signficant vehicle collision ☐ Victim of abuse (sexual, physical, domestic, neglect)
☐ Witness of violent crime ☐ Directly witnessed sudden death
☐ Severe bullying, torture ☐ War, terrorism, or natural disaster
☐ Sudden, unexpected death of a loved one ☐ Not known

_____ weeks _____ days _____ hours before death

If yes, please specify: _____

(f) The completed suicide or suicidal behaviour of a family member or loved one?

☐ 1. No ☐ 2. Yes ☐ 99. Not known

_____ weeks _____ days _____ hours before death

If yes, please specify: _____

(g) The anniversary of an important death, an important other loss or another significant anniversary?

☐ 1. No ☐ 2. Yes ☐ 99. Not known

_____ weeks _____ days _____ hours before death

If yes, please specify: _____

(h) Exposure to the suicide of another person through media or personal acquaintance?

☐ No ☐ Media ☐ Personal acquaintance ☐ Not known

_____ weeks _____ days _____ hours before death

If yes, please specify:

(i) Major financial difficulties

☐ No ☐ Lost home ☐ Repossession of belongings, e.g. car
☐ Missed mortgage repayments ☐ Bankruptcy ☐ Business failure
☐ Repeated demands from a bank or debt collector ☐ Not known

_____ weeks _____ days _____ hours before death

If yes, please specify:

(j) Experience of humiliation or loss of face (An individual suffers humiliation when he makes a bid or claim to a certain social status and has this bid or claim fail publicly)

☐ No ☐ Yes in work ☐ Yes in family life ☐ Yes among friends
☐ Yes among social media ☐ Yes, local or national scandal ☐ Not known

_____ weeks _____ days _____ hours before death

If yes, please specify:

(k) Bereavement close family or friend

☐ No ☐ Yes- family ☐ Yes-friend ☐ Yes- other ☐ Not known

_____ weeks _____ days _____ hours before death

If yes, please specify:

2. Were there any other major events that had occurred prior to the deceased's (name) death, which I have not yet mentioned?

☐ 1. No
☐ 2. Yes (If yes, ask informant about the details of the event(s) and time of occurrence before the deceased's death)

3. Had the deceased (name) expressed a wish to reunite with a deceased loved one or to be reborn?

☐ 1. No
☐ 2. Yes (please give details)

RECENT SYMPTOMS/BEHAVIOURS

Although the Depression Symptom Checklist is a self-report questionnaire, the items will be read out to the informant to allow for possible literacy problems.

The next part concerns a number of questions about feelings of depression, fatigue, quality of sleep, etc. Please read through the following list of depressive symptoms and tick any of those which were relevant to the situation of the deceased (name) in the week prior to his/her death:

How much was he/she bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely	Not known
Feeling blue						
Blaming him/herself for things						
Worrying too much about things						
Feeling everything is an effort						
Feeling low in energy or slowed down						
Feeling no interest in things						

Symptoms of Mania	Yes	No	Not known
Excessively "high" mood			
Irritability			
Decreased need for sleep			
Increased energy			
Increased talking, moving, sexual activity			
Racing thoughts			
Disturbed ability to make decisions			
Grandiose notions			
Being easily distracted			

FAMILY AND PERSONAL HISTORY

Now I would like to ask some questions regarding the family and personal history of the deceased (name). Please try to recall as best you can.

1. Did the deceased have a sibling or parent who died a non-natural death, such as suicide, homicide, or accident?

☐ 1. No ☐ 2. Yes (please give details) ☐ 99. Not known

---

2. How would you describe the level of practical and emotional support and closeness of both immediate and extended family? (Please give details)

---

3. Was there a personal (with regard to the deceased?) or family history of physical, sexual or emotional abuse?

☐ 1. No ☐ 2. Yes (please give specific details e.g. person's role in situation) ☐ 99. Not known

---

4. Was there a personal (with regard to the deceased?) or family history of substance abuse?

☐ 1. No ☐ 2. Yes (please give details) ☐ 99. Not known

---

5. Was there a family history of suicide or deliberate self-harm?

☐ 1. No ☐ 2. Yes (please give details) ☐ 99. Not known

---

6. Was there a personal (with regard to the deceased?) history of violent behaviour?

☐ 1. No ☐ 2. Yes (please give details) ☐ 99. Not known

---

6. Was there a family history of violent behaviour?

☐ 1. No ☐ 2. Yes (please give details) ☐ 99. Not known

---

7. Was there a history of mental illness/disorder in the family?

☐ 1. No ☐ 2. Yes (please give details) ☐ 99. Not known

---

8. Had either of the deceased's parents resided in an orphanage, industrial school or in foster care?

☐ 1. No ☐ 2. Yes (please give details)

LIFE EVENTS AND HISTORY

Now I would like to continue with another set of questions, which will focus on the kinds of events and problems the deceased (name) experienced in life. There will be questions relating to the deceased (name), to people who were important to him/her, and to life events. You will be asked if events occurred in his/her childhood, later in life or last year. Please answer all questions as best you can and let me know if you need any help.

	Childhood (<15 years)		Later in life (15 years +)		Last year	
	Yes	No	Yes	No	Yes	No
Did the person ever experience serious physical or mental illness?						
Details:						
Did the person ever experience serious injury?						
Details:						
Did the person ever experience serious assault?						
Details:						
Did a close relative ever experience serious illness?						
Details:						
Did a close relative ever experience serious injury?						
Details:						
Did a close relative ever experience serious assault?						
Details:						
Did the person ever experience the death of a partner, parent or child?						
Details:						
Did the person ever experience the death of a close relative or friend?						
Details:						
Did the person ever experience separation due to marital difficulties?						
Details:						
Did the person ever experience breaking off a steady relationship?						
Details:						

	Childhood (<15 years)		Later in life (15 years +)		Last year	
	Yes	No	Yes	No	Yes	No
Did the person ever experience a serious problem with a close friend, neighbour, or relative?						
Details:						
Was the person ever unemployed or seeking work unsuccessfully for more than 1 month?						
Details:						
Was the person ever fired from a job?						
Details:						
Did the person ever experience major financial crisis?						
Details:						
Did the person ever have a problem with the police and a court appearance?						
Details:						
Did the person ever have something valuable that was lost or stolen?						
Details:						
From all events and circumstances mentioned (or recorded by you yourself), which were the three most important, i.e. which three events have most strongly influenced the life of the deceased?						
Most important:						
Second most important:						
Third most important:						

HISTORY OF NON-FATAL SUICIDAL BEHAVIOUR

This part of the interview deals with questions about self-harm that may have occurred before the deceased (name) died. Examples of this behaviour are self-cutting and taking an overdose of medication.

1. (a) Prior to his/her death, did the deceased (name) ever before deliberately harm him/herself? For example, by taking an overdose of medication or drugs, by attempting to hang or drown him/herself?

☐ 1. Yes ☐ 2. No ☐ 99. Not known

1. (b) If yes, how many times? _____ ☐ 99. Not known

2. Can you tell me what you know of the last previous episode of deliberate self-harm?

A. Method

☐ 1. Overdose ☐ 2. Hanging ☐ 3. Drowning
☐ 4. Cutting ☐ 5. Jumping from height ☐ 6. Jumping in front of moving vehicle
☐ 7. Burning ☐ 8. Other type of poisoning ☐ 9. Other
☐ 99. Not known

B. Time lapse between episode of deliberate self harm and death by suicide

_____ years _____ months _____ days ☐ 99. Not known

C. Medical treatment following deliberate self-harm

1. None	
2. General Practitioner	
3. General hospital	
4. Other	
99. Not known	

D. Psychiatric treatment following deliberate self-harm

1. None	
2. Inpatient	
3. Outpatient	
99. Not known	

PRECIPITATING FACTORS FOR THE DECEASED'S LAST PREVIOUS EPISODE OF SELF-HARM

1. Now I would like to ask you about the last time when the deceased (name) harmed him/herself, prior to his/her actual death. At that time, were there any particular events or circumstances which lead to that act? (Narrative)

☐ 99. Not applicable

There may be many reasons why people try to harm themselves. Please let me know whether you think the problems that I will mention had a major influence, a minor influence or no influence at all on the deceased's (name) last previous attempt at deliberate self harm.

PROBLEM CHECKLIST (READ OUT CATEGORIES).
SKIP CATEGORIES THAT ARE CLEARLY NOT APPLICABLE

	1. No	2. Minor	3. Major	4. Don't Know
1. Problems with partner				
2. Problems with parents				
3. Problems with children				
4. Feelings of loneliness				
5. Problems in making or maintaining friendships and social relationships				
6. Rejection by a lover				
7. Physical illness or disability				
8. Mental illness and psychiatric symptoms				
9. Unemployment				
10. Addiction (to alcohol, drugs, medicines, gambling, etc)				

3. Were there any other events or circumstances that had an influence on the deceased (name) harming him/herself? (If informant mentions one or more events or circumstances, specify:)

	2. Minor	3. Major	4. Don't Know
1.			
2.			
3.			

SUICIDAL BEHAVIOUR BY PERSON'S KNOWN TO THE DECEASED (MODELS).

To your knowledge, have any of the deceased's relatives or close friends ever deliberately harmed him or herself? Can you tell me about the circumstances of this?

A. List consecutively relationship of model to subject (model was/is subject's...)

1. Wife					
2. Husband					
3. Cohabitee					
4. Daughter					
5. Son					
6. Mother					
7. Father					
8. Sister					
9. Brother					
10. Grandmother					
11. Grandfather					
12. Other relative					
13. Close friend					

For each please identify in box as follows: Hanging = **H**; Overdose = **OD**; Cutting = **SC**; Firearms = **F**; Drowning = **D**; Poisoning = **P**; Other = **O**; Yes but method not specified = **NK**

B. Type of behaviour

1. Deliberate self-harm					
2. Suicide					

C. Time lapse between model event and death (in order of which family members appear in A)

1. less than 1 day					
2. less than 1 week					
3. less than 1 month					
4. less than 3 months					
5. less than 12 months					
6. 12 months or more					

CONTACT WITH HEALTH CARE SERVICES

I would now like to ask some questions about the contact the deceased (name) had with the health care services, both with his/her GP and with mental health care professionals. Please try to recall as best you can.

1. (a) In the year prior to death, did the deceased (name) have contact with his/her GP or other mental health services?

☐ 1. No ☐ 2. Yes (please give details) ☐ 99. Not known

(b) Do you know the (approximate) date of the last contact with the GP or other mental health services?

☐☐-☐☐-☐☐☐☐
Day Month Year

Reason: ☐ 1. Physical ☐ 2. Psychological ☐ 3. Both physical and psychological
☐ 99. Not specified ☐ Not applicable

(c) If the deceased (name) contacted their GP in the last year, how many times was this?

☐ 1. no contact ☐ 2. 1 time ☐ 3. 2 times
☐ 4. 3 times ☐ 5. 4 or more times ☐ 99. Not known

If medicines were prescribed did the deceased use any of the medicines prescribed in that contact for self-poisoning/overdose?

☐ 1. No ☐ 2. Yes (please give details) ☐ 99. Not known ☐ Not applicable

---

(d) Did the deceased ever have with a mental disorder?

Diagnosed	Likely	
☐	☐	01. Schizophrenia and/or other psychotic disorders
☐	☐	02. Bipolar affective disorder
☐	☐	03. Depressive illness
☐	☐	04. Anxiety/phobia/panic disorder/OCD
☐	☐	05. Eating disorder
☐	☐	06. Dementia
☐	☐	07. Alcohol dependence
☐	☐	08. Drug dependence
☐	☐	09. Personality disorder
☐	☐	10. Adjustment disorder/reaction
☐	☐	11. Organic disorder (e.g. acquired brain injury)
☐	☐	12. Alcohol misuse, but not dependence
☐	☐	13. Drug misuse, but not dependence

☐ 77. No mental disorder ☐ 88. Other (please specify disorder) ☐ 99. Not known

---

2. (a) Was the deceased (name) ever treated as an inpatient at a psychiatric hospital or on the psychiatric ward of a general hospital?

☐ 1. No ☐ 2. Yes No. of times: _____ ☐ 99. Not known

If yes, please give details (e.g. number of admissions, reason for admission)

(b) How many times in the year prior to death?

☐ 1. Never ☐ 2. 1 time ☐ 3. 2 times ☐ 4. 3 times
☐ 5. 4 times or more ☐ 99. Not known

(c) If the deceased (name) received inpatient psychiatric treatment in the year prior to death, do you know for how many weeks?

Number of weeks: _____

If informant cannot remember the exact number of weeks, ask to indicate if the duration was:

☐ less than 4 weeks ☐ between 4 and 16 weeks ☐ between 16 and 52 weeks
☐ other ☐ 99. Not known

3. If the deceased (name) died following discharge from inpatient psychiatric treatment do you know the date of discharge?

☐☐-☐☐-☐☐☐☐ ☐ 99. Not known
Day Month Year

4. (a) Was the deceased (name) offered outpatient appointments with the mental health services in the year before death?

☐ 1. No ☐ 2. Yes ☐ 99. Not known

Please specify type:

☐ 1. Psychiatric service- public ☐ 2. Private psychologist/psychiatrist
☐ 3. Community mental health nurse ☐ 4. Alcohol/Drug Addiction services
☐ 5. Consultation service for relationship/sexual problems

(b) If yes, please indicate to the best of your knowledge if the deceased (name) had any difficulty attending these appointments?

☐ 1. No ☐ 2. Yes ☐ 99. Not known

(c) To the best of your knowledge did the deceased (name) feel they benefited from the services?

☐ 1. No ☐ 2. Yes ☐ 99. Not known

5. Was the deceased (name) on prescribed medication for mental illness in the year prior to death?

☐ 1. No ☐ 2. Yes ☐ 99. Not known

6. Do you know the name of the medication?

☐ 1. No ☐ 2. Yes (If yes please specify)

_____

7. To the best of your knowledge, did he/she comply with the instructions on the medication?

☐ 1. No ☐ 2. Yes (please give details) ☐ 99. Not known

_____

8. Do you know of any difficulties which the deceased (name) faced in accessing health care services?

☐ 1. No ☐ 2. Yes (please specify below) ☐ 99. Not known

_____

9. Did the deceased (name) have contact with any support group?

☐ 1. No ☐ 2. Yes (please give details) ☐ 99. Not known

_____

10. Name and contact details (if known) of health care professional

_____

☐ 99. Not known

PHYSICAL HEALTH

Now I would like to ask you about the deceased's (name) physical well being. Please try to recall your knowledge of any physical illnesses or pain which the deceased (name) may have suffered from.

1. Had the deceased (name) been diagnosed with any significant physical illness or disease? (Include conditions even if well controlled by treatment)

☐ 1. No ☐ 2. Yes (please specify which illness(es)) ☐ 99. Not known

---

2. Was the deceased (name) in physical pain in the year prior to death?

☐ 1. No ☐ 2. Yes (please give details e.g. duration) ☐ 99. Not known

---

3. Was this physical illness chronic? (i.e. duration over 12 months)

☐ 1. No ☐ 2. Yes ☐ 3. Not applicable ☐ 99. Not known

4. Did the deceased (name) experience a reduction in his/her physical capabilities prior to his/her death?

☐ 1. No ☐ 2. Yes (please give details e.g. duration) ☐ 99. Not known

---

5. Was the deceased (name) on prescribed medication for a physical illness?

☐ 1. No ☐ 2. Yes ☐ 99. Not known

If yes to the best of your knowledge, did he/she adhere to the instructions on the medication?

☐ 1. No ☐ 2. Yes ☐ 99. Not known

(please give details)

SUBSTANCE ABUSE

I would now like to ask you about the deceased's (name) use, if relevant, of alcohol and drugs and about any recent changes in this behaviour in the year prior to death.

1. Did the deceased have a history of alcohol abuse?

☐ 1. No ☐ 2. Yes (please give details) ☐ 99. Not known

---

2. Had the deceased made any recent attempts, (in the year prior to death) to stop abusing alcohol for example, abstinence or addiction treatment?

☐ 1. No ☐ 2. Yes (please give details) ☐ 99. Not known

---

3. Was there a recent increase in the deceased's abuse of alcohol?

☐ 1. No ☐ 2. Yes (please give details) ☐ 99. Not known

---

4. Was there any evidence that the deceased had been drinking at the time of death?

☐ 1. No ☐ 2. Yes (please give details) ☐ 99. Not known

---

5. Did the deceased have a history of drug abuse?

☐ 1. No ☐ 2. Yes (please give details) ☐ 99. Not known

---

6. Had the deceased made any recent attempts, (in the year prior to death) to stop abusing drugs for example, abstinence or addiction treatment?

☐ 1. No ☐ 2. Yes (please give details) ☐ 99. Not known

7. Was there a recent increase in the deceased's abuse of drugs?

☐ 1. No ☐ 2. Yes (please give details) ☐ 99. Not known

8. Was there any evidence that the deceased had been taking drugs at the time of death?

☐ 1. No ☐ 2. Yes (please give details) ☐ 99. Not known

WORK SITUATION

This part of the interview covers the work situation of the deceased (name) and how their work fitted into everyday life. (If the person was not employed, then answer in reference to their last job)

Notes:

	To a very large extent	To a large extent	Somewhat	To a small extent	To a very small extent	Not known	Not applicable
1. Was the deceased (name) worried about becoming unemployed?							
2. Was the deceased (name) worried about new technology making them redundant?							
3. Was the deceased (name) worried about it being difficult for them to find another job if they became unemployed or ran out of business?							
4. Was the deceased (name) worried about being transferred to another job against their will?							

5. Did the deceased (name) often feel a conflict between their work and their private life, making them want to be in both places at the same time?

☐ Yes, often ☐ Yes, sometimes ☐ Rarely ☐ No, never
☐ Not known ☐ Not applicable

	Yes, certainly	Yes, to a certain degree	Yes, but only very little	No, not at all	Not known	Not applicable
6. Did the deceased (name) feel that their work drained so much of their energy that it had a negative effect on their private life?						
7. Did the deceased (name) feel that their work took so much of their time that it had a negative effect on their private life?						
8. Did the deceased (name)'s friends or family tell them that they worked too much?						

	Always	Often	Sometimes	Seldom	Never/ hardly ever	Not known	Not applicable
9. Was there a good atmosphere between the deceased (name) and their colleagues?							
10. Was there good co-operation between the colleagues at the deceased (name)'s work?							
11. Did the deceased (name) feel part of a community at their place of work?							

	Strongly disagree	Disagree	Agree	Strongly Agree	Not known	Not applicable
12. Did the deceased (name) job require him/her to work very fast?						
13. Did the deceased (name)'s job require him/her to work very hard?						
14. Did the deceased (name)'s job require too great a work effort?						
15. Did the deceased (name) have sufficient time for all his/her work tasks?						
16. Did the deceased (name) have the opportunity to learn new things in his/her work?						
17. Did the deceased (name)'s job require creativity?						
18. Did the deceased (name)'s job require doing the same tasks over and over again?						
19. Did the deceased (name) have the possibility to decide for him/herself how to carry out his/her work?						
20. Did the deceased (name) have the possibility to decide for him/herself what should be done in his/her work?						
21. Was there a quiet and pleasant atmosphere at the deceased (name)'s place of work?						
22. Was there good collegiality at the deceased (name) work?						
23. Were the deceased (name)'s co-workers (colleagues) there for him/her (to support him/her)?						
24. Did people at work understand that the deceased (name) may have had a "bad" day?						
25. Did the deceased (name) get along well with his/her supervisors?						
26. Did the deceased (name) get along well with his/her co-workers?						

ASPECTS OF PERSONALITY

This part of the interview covers some aspects of the deceased (name)'s personality and how he/she tended to act in different situations.

	True	False	Not known
1. He/she would often say whatever came into his/her head without thinking first.			
2. He/she enjoyed working out problems slowly and carefully			
3. He/she would frequently make appointments without thinking about whether he/she would be able to keep them.			
4. He/she frequently bought things without thinking about whether or not he/she could really afford them.			
5. He/she often made up his/her mind without taking the time to consider the situation from all angles.			
6. Often, he/she didn't spend enough time thinking over a situation before he/she acted			
7. He/she often got into trouble because he/she didn't think before he/she acted.			
8. Many times the plans he/she made didn't work out because he/she hadn't gone over them carefully enough in advance.			
9. He/she rarely got involved in projects without first considering the potential problems.			
10. Before making any important decision, he/she carefully weighed the pros and cons.			
11. He/she was good at careful reasoning.			
12. He/she often said and did things without considering the consequences.			

COPING STYLE

We are interested in how people respond when they confront difficult or stressful events in their lives. There are lots of ways to try to deal with stress. This questionnaire asks you to indicate what the deceased (name) generally did and felt, when he/she experienced stressful events. Obviously, different events bring out somewhat different responses, but think about what he/she usually would do when he/she was under a lot of stress

	Had been doing this...				
	Not at all	A little bit	A medium amount	A lot	Not known
1. He/she had been turning to work or other activities to take his/her mind off things.					
2. He/she had been concentrating his/her efforts on doing something about the situation he/she was in.					
3. He/she had been saying to him/herself "this isn't real".					
4. He/she had been using alcohol or other drugs to make him/herself feel better.					
5. He/she had been getting emotional support from others.					
6. He/she had been giving up trying to deal with it.					
7. He/she had been taking action to try to make the situation better.					
8. He/she had been refusing to believe that it had happened.					
9. He/she had been saying things to let his/her unpleasant feelings escape.					
10. He/she had been getting help and advice from other people.					
11. He/she had been using alcohol or other drugs to help him/her get through it.					

12. He/she had been trying to see it in a different light, to make it seem more positive.					
13. He/she had been criticizing him/herself.					
14. He/she had been trying to come up with a strategy about what to do.					
15. He/she had been getting comfort and understanding from someone.					
16. He/she had been giving up the attempt to cope.					
17. He/she had been looking for something good in what is happening.					
18. He/she had been making jokes about it.					
19. He/she had been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.					
20. He/she had been accepting the reality of the fact that it had happened.					
21. He/she had been expressing his/her negative feelings.					
22. He/she had been trying to find comfort in his/her religion or spiritual beliefs.					
23. He/she had been trying to get advice or help from other people about what to do.					
24. He/she had been learning to live with it.					
25. He/she had been thinking hard about what steps to take.					
26. He/she had been blaming him/herself for things that happened.					
27. He/she had been praying or meditating.					
28. He/she had been making fun of the situation.					

RELIGIOUS BELIEFS AND SPIRITUALITY

We are now going to ask you some questions about religious and spiritual beliefs. Please try to answer them even if you and the deceased (name) have little interest in religion. In using the word religion, we mean the actual practice of a faith, e.g. going to a temple, mosque, church or synagogue. Some people do not follow a specific religion but do have spiritual beliefs or experiences. For example, they may believe that there is some power or force other than themselves that might influence their life. Some people think of this as God or gods, others do not. Some people make sense of their lives without any religious or spiritual belief.

1. Therefore, would you say that the deceased (name) have a religious or spiritual understanding of his/her life?

☐ Religious ☐ Religious and spiritual
☐ Spiritual ☐ Neither religious nor spiritual ☐ Don't know

If the deceased (name) has NEVER had a RELIGIOUS or SPIRITUAL BELIEF, please go to Question 13.

2. Some people hold strongly to their views and others do not. How strongly did the deceased (name) hold to his/her religious/spiritual view of life?

Weakly held view **0 1 2 3 4 5 6 7 8 9 10** Strongly held view

3. Did any of the following play a part in the deceased (name)'s belief?

Prayer ☐ Alone ☐ With other people
Ceremony ☐ Alone ☐ With other people
Meditation ☐ Alone ☐ With other people
Reading and study ☐ Alone ☐ With other people
Contact with religious leader ☐ Alone ☐ With other people
None of the above ☐

7. How important to the deceased (name) was the practice of his/her belief (e.g. private meditation, religious services) in his/her day-to-day life?

Not Necessary **0 1 2 3 4 5 6 7 8 9 10** Essential

8. Did the deceased (name) believe in a spiritual power or force other than him/herself that could influence what happened to him/her in his/her day-to-day life?

No Influence **0 1 2 3 4 5 6 7 8 9 10** Strong Influence

9. Did the deceased (name) believe in a spiritual power or force other than him/herself that enabled him/her to cope personally with events in his/her life?

No Help **0 1 2 3 4 5 6 7 8 9 10** A Great Help

10. Did the deceased (name) believe in a spiritual power or force other than him/herself that influences world affairs, e.g. wars?

No Influence **0 1 2 3 4 5 6 7 8 9 10** Strong Influence

11. Did the deceased (name) believe in a spiritual power or force other than him/herself that influences natural disasters, like earthquakes, floods?

No Influence **0 1 2 3 4 5 6 7 8 9 10** Strong Influence

12. Did the deceased (name) communicate in any way with a spiritual power, for example by prayer or contact via a medium?

Yes ☐ No ☐ Unsure ☐

13. Did the deceased (name) think that we exist in some form after our death?

Yes ☐ No ☐ Unsure ☐

SOCIAL NETWORK

This part of the interview covers the social network of the deceased (name) and any changes in relationships with significant people in his/her life during the year prior to death. In your own words, how would you describe the deceased (name)'s relationships with significant people in his/her life?

	Hardly ever	Some of the time	Most of the time	Not known
1. Did he/she feel he/she had a definite role in the family and among friends?				
2. Did he/she feel understood by his/her family and friends?				
3. Did he/she feel useful to family and friends?				
4. Did he/she feel listened to by family and friends?				
5. Did he/she know what was happening with family and friends?				
6. Could he/she talk about his/her deepest problems?				

7. Number of family members within 1 hour that he/she could depend on or felt close to: _____

☐ Not known

8. (Other than at work) How many times during a typical week did he/she spend some time with someone who did not live with him/her, that is, went to see them or they came to visit him/her, or they went out together?

☐ None ☐ once ☐ twice ☐ three times ☐ four times
☐ five times ☐ six times ☐ seven times or more ☐ Not known

9. (Other than at work) How many times did he/she talk to someone - friends, relatives or others - on the telephone in a typical week (either they called him/her, or he/she called them)?

☐ None ☐ once ☐ twice ☐ three times ☐ four times
☐ five times ☐ six times ☐ seven times or more ☐ Not known

10. (Other than at work) About how often did he/she go to meetings of social clubs, religious meetings, or other groups that he/she belonged to in a typical week?

☐ None ☐ once ☐ twice ☐ three times ☐ four times
☐ five times ☐ six times ☐ seven times or more ☐ Not known

11. Did the deceased (name) consider him/herself to be:

☐ Heterosexual or straight;
☐ Gay or lesbian;
☐ Bisexual?

12. How long were you acquainted with the deceased? Years: _____

13. How close did you feel to the deceased (name)?

☐ Fully close ☐ very close ☐ moderately close ☐ Neither close nor distant ☐ Distant

14. Did you talk to them openly?

☐ Never ☐ Sometimes ☐ Generally ☐ Always

INFORMANT'S WELLBEING

Now we are coming to the end of the interview. Up to this point, the interview has focused on the deceased (name). This part of the interview covers your own wellbeing, and particularly how you've been feeling over the past week. Please indicate how often you have experienced the following.

	Never	Some-times	Often	Almost always
1. I found it hard to wind down				
2. I was aware of dryness of my mouth				
3. I couldn't seem to experience any positive feeling at all				
4. I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)				
5. I found it difficult to work up the initiative to do things				
6. I tended to over-react to situations				
7. I experienced trembling (eg, in the hands)				
8. I felt that I was using a lot of nervous energy				
9. I was worried about situations in which I might panic and make a fool of myself				
10. I felt that I had nothing to look forward to				
11. I found myself getting agitated				
12. I found it difficult to relax				
13. I felt down-hearted and blue				
14. I was intolerant of anything that kept me from getting on with what I was doing				
15. I felt I was close to panic				
16. I was unable to become enthusiastic about anything				
17. I felt I wasn't worth much as a person				
18. I felt that I was rather touchy				
19. I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)				
20. I felt scared without any good reason				
21. I felt that life was meaningless				

THANK YOU FOR COMPLETING THIS INTERVIEW

ADDITIONAL INFORMATION

You may have important additional information that has not already been covered in the interview. Would you like to add anything else?

(Please use this section to record any additional information the informant wishes to share).

CONTACT WITH ONE OF MORE HEALTHCARE PROFESSIONALS

You mentioned one or more healthcare professionals who were in contact with the deceased (name) within 12 months prior to his/her death. If you agree I would like to contact him/her/them.

Do you agree?

☐ 1. No ☐ 2. Yes

CONTACT WITH A PEER

You mentioned one or more friends who were in contact with the deceased (name) within 12 months prior to his/her death. If you agree I would like to contact him/her/them.

Do you agree?

☐ 1. No ☐ 2. Yes

CONTACT DETAILS:

Name:

Phone number:

Address:

BEREAVEMENT SUPPORT

I would now like to ask if you are currently receiving or have received bereavement support. If not, would you like to access bereavement support at this time? If yes, are you satisfied with the support you have received?

POSSIBILITY OF FURTHER FOLLOW-UP

It is often very valuable to follow up participants in a study to see how their situation and views change over time. Even though we do not currently have funding to so this, there is a possibility that we may have scope to meet with participants again in the coming years. We would not be able to contact you unless we obtain permission now to make contact in the future. Even if you agree now to be contacted, you can decide in the future not to take part in a follow-up. Would you be satisfied for us to keep the option open for future contact?

I hereby give permission to be contacted in future in relation to further research, but I understand that I am not obliged to take part.

☐ 1. No ☐ 2. Yes

Name: Signed:

Date: ☐☐-☐☐-☐☐☐☐

Appendix 6

SSIS-PAM

Thank you for agreeing to take part in our study. The purpose of this form is to make sure that you agree to take part in the research and that you know what it involves.

Following the interview in which you took part, we would also like to ask your relative's GP to provide us with some additional information about the deceased. However, you can notify us if you do not agree with this. The information will help us to obtain insight into aspects of your life from a clinical perspective.

1. I confirm that I have read and understood the information sheet for the study, received a copy and have had the opportunity to ask questions

☐ Yes ☐ No

2. I understand that the data obtained within this study will be stored securely in an anonymised manner.

☐ Yes ☐ No

3. I give permission for the deceased's GP to complete a "Health care professional questionnaire" with further information on his/her general and mental health.

☐ Yes ☐ No

CONTACT DETAILS:

Name (BLOCK CAPITALS):

Phone:

Email:

Signature:

Date: ☐☐-☐☐-☐☐☐☐

THANK YOU FOR YOUR COLLABORATION.

NOTES

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National Suicide Research Foundation